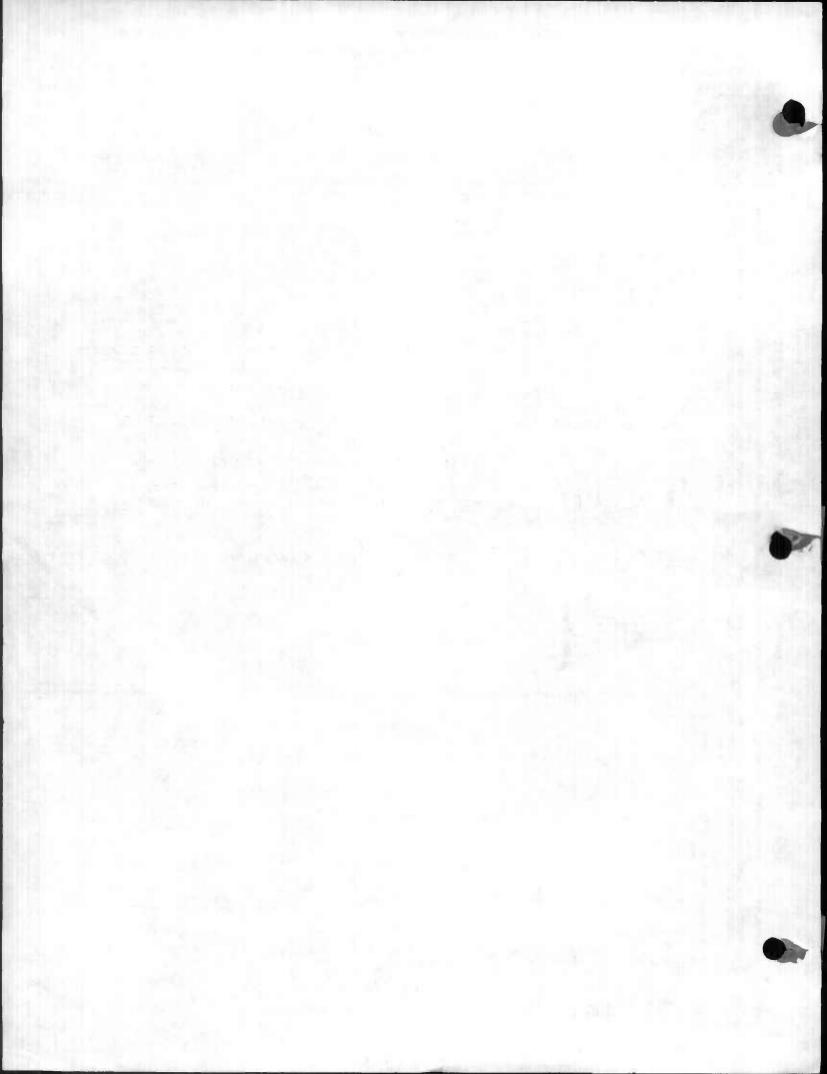
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 26001

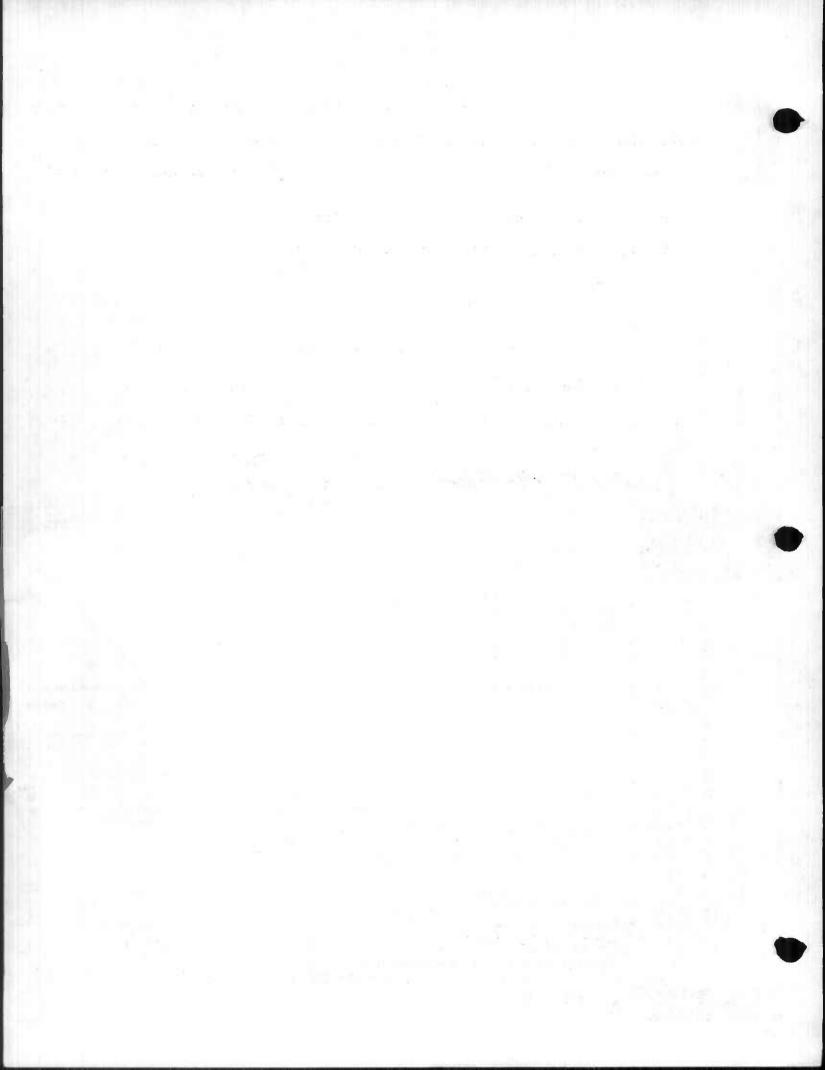
			_		e of				g. No.		.0001
	1. Decedent's Neme (First, Middle, I	Last)						2. Dete of Death Month	Day	Year	3. Time of Dea
ysician Medical	Charles Joh			P	ugust	15 20	000	9:04 P			
	4e Fecility Name (If not institution, g					4b. City, To	wn, or Loc	ation of Deeth	4c. County	of Deeth	
	Gilchrist					Tows	on		Balt	imore	е
eral	Sociel Security Number 6.		e (In yrs. lest birtho	(ey) If Under	r 1 Yeer	If Under	24 Hrs. Min.	8. Dete of Birth (Month, Dey, larch I	Veer)	9. Births	plece (Stete or Fo
tor	164-07-9202	1⊠M 2□F	90 Yrs	3. MONTHS	Deys	nours	IVIII.	March I	1910	New	York
-	Usuel Residence of Decedent										
	10e. Stete 10b. County		10c. City, Town o	r Location						1	10d. Inside City Li
Ş	Md. Baltimo	ore	Timonium								1□Yes 2Ē
Director	10e. Street and Number			10f. Zi	Code			10	og. Citizen of \	What Cour	ntry?
	157 Springsid	de Dr.		2	1093					USA	
Funeral	11. Maritel Stetus	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Dece	dent of H	lispenic Ori	gin? (Spec	cify Yes or No- lican, etc.)		ca - Americ	can Indien,
	1 Never Merried 2 Married	'wwII			Specify:	, Fuerto F	noan, etc./				
remarked other train "satural", or treumatic event, trained at Earn To Be Completed by F	3 Widowed 4 Divorced	Yeer or Detes:	MANTT	1 108	212-140	Specify.			Specify	Wh	ite
	15. Decedent's	16a. D	ecedent's Usu	at Occup	etion	of workin	0	16b. Kind of B	usiness/In	dustry	
	(Specify only highest s Elementery/Secondery (0-12)	College (1-4or 5	()	rive kind of wi	se retired	d)	Of WORKIN				
		+4				he Au	dito	c	Steel	Indu	stry
	17. Fether's Neme (First, Middle, La	ist)	18. Mother's Neme (First,						faiden Sumen	ne)	
	Charles N	Miller	er Caroly					Singer			
	19e. Informent's Neme/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Ste								, Stete, Zij	p Coda)	
	Mrs. Ruth Miller	/ Wife	157	7 Sprin	gsid	de Dr.	Time	onium, 1	Md. 210)93	
	20e. Method of Disposition		20b. Place of D	isposition (Na	ma of			Date	20c. Location	- City or T	own, Stete
poce	1 ☑ Buriel 2 ☐ Cremetion 3			cremetory or				10 00	no+blok	0 0 m	Da
	4 □ Donetion 5 □ Other (Spe-		Nisky H	22. Name e	***	_		19-00	Bethler	iem,	ra.
Suce	21. Signistate of Furieral Salvice Lit		10 P. C. T.					al Home	, Inc.		
	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204										
	23e. Pert V. Enter the disease, or/co shock, or heart feilure. Lts/ or	omplication that caused my one cause on each li	I tha death. Do not na.	enter the mo	de of dyir	ng, such as	cardiac or	respiretory erro	est,	1	Approximete Interval Between
an				/							Onset end Dea
al	Immediate Cause (Final disease or condition	. Dr	mcr	ent	ic	C	Ano	cer			3 mm
er	resulting In death)		Due to (or as e co							1	
ai Examine		- b								1	
Examiner	Sequentially list conditions, Due to (or es e consequence of):										
E E	if any, leeding to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated evants										
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any		- d									
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- 50	Part II. Other significant conditions	ds contributing to death b	ut not resulting in t	na underlying	cause giv	ven in Pert I	l.	23b. Did to	bacco uss co	ontributs t	lo the causs of d
hys	Part II. Other algnificant conditions	ds contributing to death b	ut not resulting in th	ha underlying	cause giv	ven in Pert I	l.	23b. Dld to	A		to the causs of dobably 4 Uni
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by Phys	Part II. Other algnificant conditions	ds contributing to death b	ut not resulting in t	ha underlying	cause giv	ven in Pert I		1 □ Y	n eutopsy	3 □ Pro	obably 4 ☐ Uni
þ	Part II. Other significant conditions	ds contributing to death b	ut not resulting in th	na underlying	cause gin	ven in Pert I	l.	1 🗆 Y	n eutopsy	3 □ Pro	Vere eutopsy find
þ	Part II. Other significant conditions	ds contributing to death b	ut not resulting in the	na underlying	cause gin	ven in Pert I		1 □ Y 24a. Wes e perfori	n eutopsy	3 Pro	Obably 4 Uni
Completed by		ds contributing to death b	ut not resulting in th	na underlying	cause giv			1 Y	n eutopsy ned?	3 Pro	Vere eutopsy find veileble prior to completion of caus f daath?
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decadant's Nama (First, Middle, Last) 2. Data of Daath Yaar **Physician** Month John Frederick MacKenzie AUSUST :40 pm 15 2000 /Medical 4a. Facility Nema (If not Institution, giva straat and number) 4b. City, Town, or Location of Daath Examiner 4c. County of Daath 7. Aga (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | SEP 27, 10 715 Maiden Choice Ln., #523 Chapel Court Baltimore 6. Sax 1 M 2 F 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) **Funerai** 082-09-7666 Director New York Usual Residence of Dacadent the Maryland 10a. State r 28a-f show 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yes 2X No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? must be r deeth with 715 Maiden Choice Ln., # 523 Chapel Court 21228 USA Funeral 12. Was Decedent Ever in U,S. Armad Forcas? 1 XYas 2 □ No If Yès, Giva Yaar or Datas: WW II Herris 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. filed within 72 hours efter 1 ☐ Nevar Married 2 X Marriad 21215-0020 6 1 ☐ Yas 2 ☒ No Spacify: ģ 3 Widowed 4 Divorcad Specify. White "natural", Pages 1 end 2 should be filed within 72 ho nent of Health and Mental Hygiene. Int: If Item 27 Is merked other than "natur Iry or other traumetic event, Tre Medical. Completed 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) School Teacher 5+ Public High School Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnema) Be Neil Alexander MacKenzie Emma Huebner 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Dorothy A. MacKenzie / wife 715 Maiden Choice Ln., #523 Chapel Ct. Balto., MD 21228 20b. Plece of Disposition (Nama of cematary, cramatory or other pleca) 20a. Mathod of Disposition Data 20c. Locetion - City or Town, Stete 1 ☐ Burial 2 X Cramation 3 ☐ Removal from Stata permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Spacify) Metro Crematory, Inc. 08/16/00 Baltimore, MD 21. Signature of Funaral Service Licansas Mar Maff 22. Nama and Address of Facility. Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD George E. MacNabb 21228 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such es cerdiac or raspiratory errest, shock, or heert feilure. List only one cause on each line. **Physician** /Medical Immediete Ceusa (Final METASTATIC PROSTATE CANCER Years diseasa or condition rasulting in daath) Examiner Due to (or es e consequance of) The law requires that the death certificete be executed Sequantially list conditions, if any, laading to Immadiata causa. Entar Underlying Cause (Disaasa or Injury that Initiated avants rasulting In death) Last Bnd Due to (or as a consaguance of): Box 68760. physician Physician/Medical the Dua to (or es e consequance of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. o 23b. Did tobacco use contributs to the cause of death? م 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed performad' hes certificete 1 Yas 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s efter deeth. Il Director: After this certificet ed in by the funeral director, pa 25. Wes cesa raferred to medicel axaminer? Be 26. Placa of Daath (Check only ona) Hospital: Othar: 4□ Nursing Homa 5 Rasidance 6 □ Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Netural 28e. Deta of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? 5 Panding 1 Tes 2 No 2 Accident Invastigation 3 ☐ Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 4 - Homicide Hospital 24 hours 24 hours edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

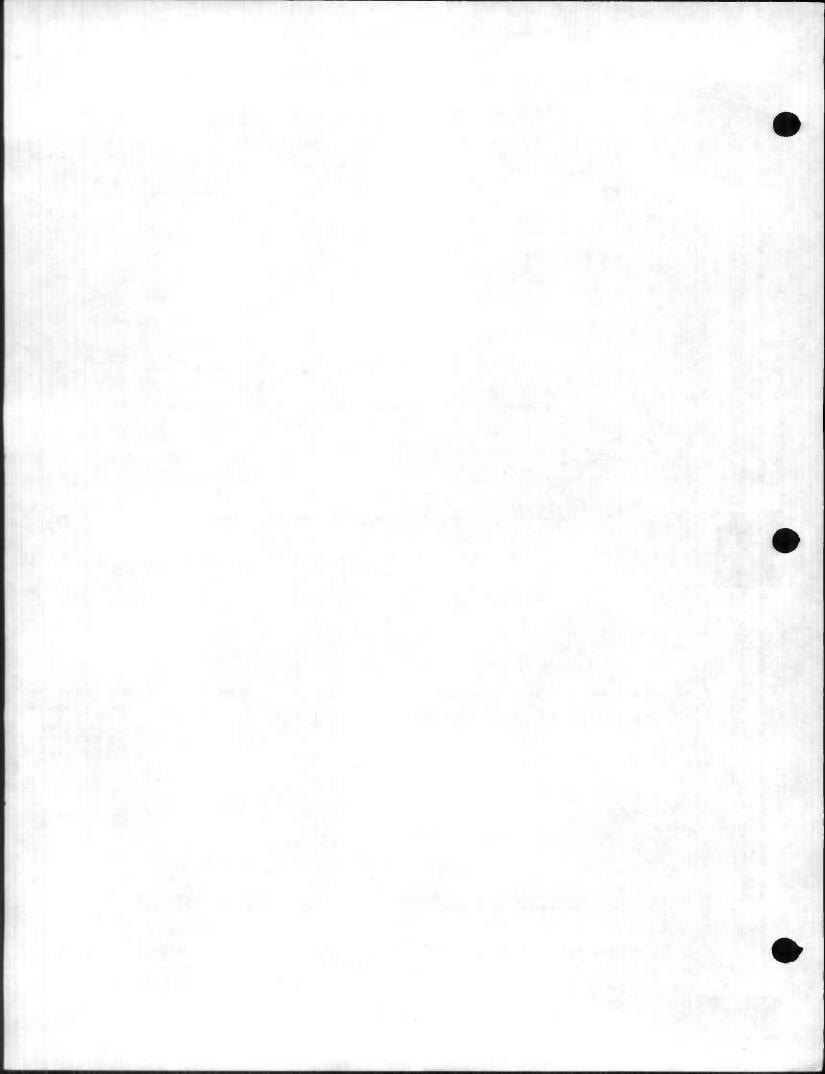
2 Medical Examinar: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Cartifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) D76473 LOVS KY, IN 714 A BEALLE HOICE LANE, BALTINORE, MD. 21278
32. Registral Sonatura 30. Manue end addrass of person who completed causa of daath (Itam 23a) (Type, Print) Dernard LOZLOVS KY, M State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** 1:55 am Genevieve Mitchell 2000 August /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview medical Center Baltimore Baltimore City # Under 1 Yeer If Under 24 Hrs. 8 Data of Birth (Month, Dey, Year)

Feb. 26, 1 7. Age (In yrs. last birthday) 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** 1□M 20 F 216 24 4001 70 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Nama 23a or 28a-f show 1 Yes 2 No Maryland Anne Arundel Severn Directo the Medical Examiner must be notth 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7746 Twin Oaks Road 21144 U.S. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 72 hours after 1 Yes 2 No If Yas, Give Yeer or Detes: 1 Never Merried 2X Merried 8 Maryland 21215-0020 1 Yes 2 No Specify: Specify: by White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+)
2 years Elementery/Secondary (0-12) Cashier Automobile years 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental should be Gladys Hudson Walter Beach 19a. Intorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Health Hem 27 Melvin Mitchell / Husband 7746 Twin Oaks Road Severn, Maryland 21144 Baltimore, 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Pages Department of important: If it any injury or o 18 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Glen Haven Memorial Park 8/14/00 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 gramerouski licetions that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, one cause on each line. 236. Part 1. Enter the disease shock, or heart failure. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure ten days **Examiner** Due to (or es a consequence of) Physician/Medical Examiner Cancer two years Colon The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last the burief-tren Due to (or es a consequence ot): and Possible Sepsis ten days Box 68760. the attending physician Dua to (or es e consequenca ot): fibrillation five years trial Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Diabetes Mellitus type two of Vital Records. by 24b. Were autopsy tindings evailable prior to completion of cause ot death? if or Attending Physician: The law require after death. I Director: After this certificate has been sid of in by the funeral director, page 2 should I Be Completed 24e. Wes an autopsy performed' 2 12 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, tectory, offica building, etc. (Specify) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. edicai 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) folloman Resident Physician 21015 11,2000 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gottesman, 4940 Eastern Avenue, Baltimore, Moryland 21224 Rebecca 31. Data tiled (Month, Day, Year) 32. Registrar's Signature State AUG 1 7 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 39 AUGUST NATALIA MACENKO ,2000 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death STELLA MARIS AT MERCY BALTIMORE If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 F Yrs. 80 FEB. 18,1920 UKRAINE 213-32-7387 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 XYes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 S. MADIERA STREET 21231 UKRAINE 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify: 3℃Widowed 4 Divorced Year or Dates: WHITE 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 DOMESTIC JANITORIAL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) WASILIUS LUCYSZYN ANASTASIA RIZNYK 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ANNA STRYZAK/ DAUGHTER 6409 EASTERN PARKWAY, BALTIMORE, MARYLAND 21214 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MICHAEL'S UKRAINIAN 8/19/00 BALTIMORE, MARYLAND 22. Name end Address of Facility 21. Signature of Funeral Service Licenses LILLY & ZEILER INC. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 21231 Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequenca of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one Stella MARIS AT MERO Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence & Other (Specify) HOSpice 1 Yes 2 No 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 11 ENatural 5 ☐ Pending investigation 1 TYes 2 TNo 2 Accident 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

The law requires that the death certificate be any Box 68760, P.O. Records, of Vital Division ò **Physician**

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State Registrar 31. Date filed (Month, Day, Year) AUG 1 7 2000

29b. Signature and title of certific

RISEBERG 301 SY 32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

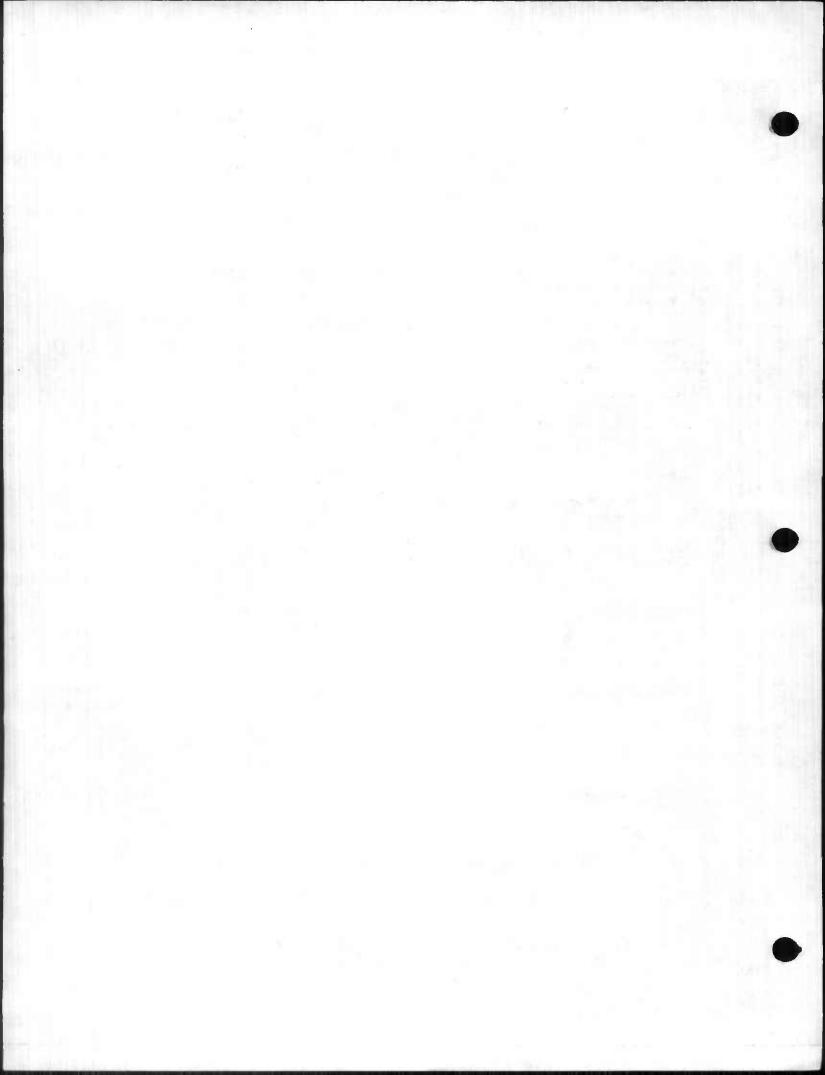
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

140854

29d. Date signed (Month, Day, Year)

BAHIMORE MD 21202



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 26005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ERNA HEDWICK PETLICKA AUGUST 12:10 PM 2000 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BROOKE GROVE REHABILITATION AND NURSING CENTER SANDY SPRING MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1□M 2以F 087-18-8471 93 Sept. 8 1907 Germany Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Montogemery Laytonsville 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Counfry? 6401 Manor View Drive 20882 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) unavailable Minna Quade 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Dorothy, Schmitt - Niece 6401 Manor View Drive Laytonsville, Md 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) 8/14/00 Burtonsville. Maryland 5 ☐ Other (Specify) Union Cemeteru ineral Service Line 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 ons that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death nly one cau Immediete Ceuse (Final . INANITION diseese or condition resulting in death) WEEKS Due to (or as a consequence of): VASCULAR DEMENTIA Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avellable prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medicai Examiner

The law requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital or Attending Physician: **Physician**

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be filed within 72 hours after death with the Maryland

21215-0020

Baltimore, Maryland

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Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was cese referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigetion 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one)

29c. License number

D42046

29d. Date signed (Month, Dey, Year)

August 11, 2000

State Registrar

Medical

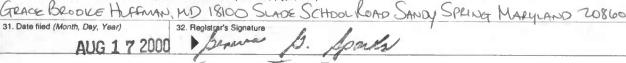
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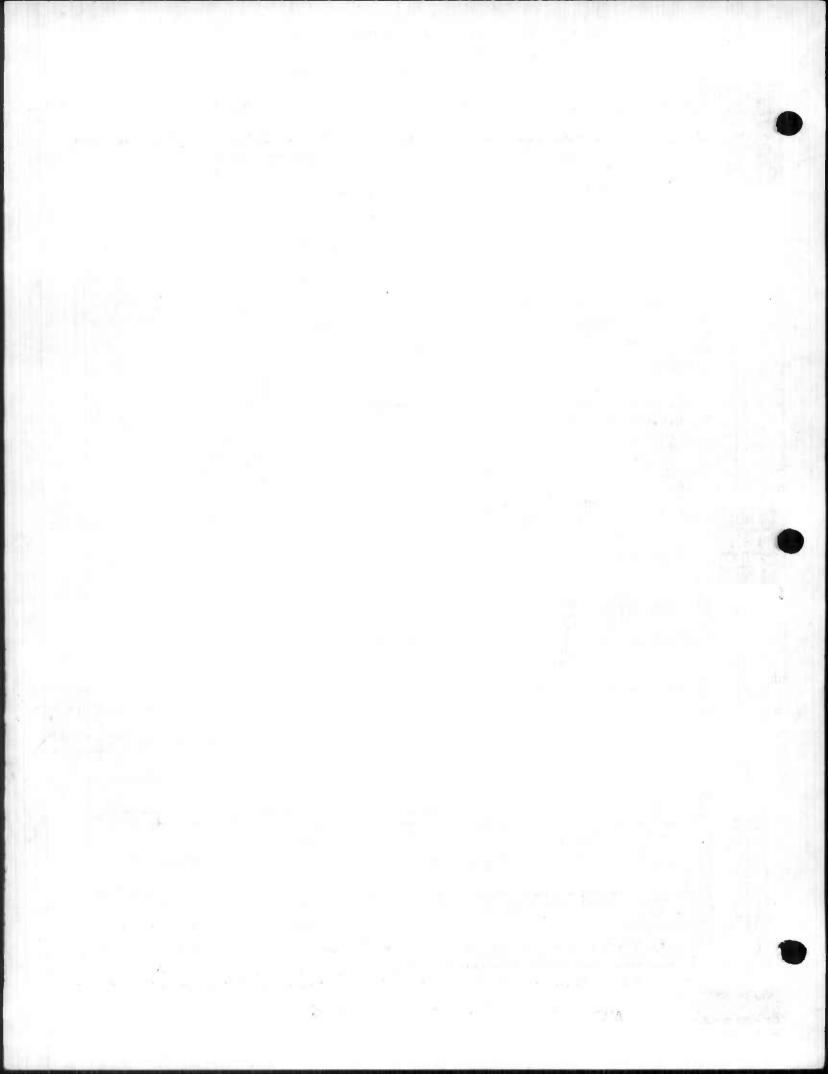
STAFF PHYSICIAN

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signature and fitle of certifier

31. Date filed (Month, Day, Year)





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) Day Year **Physician** LEON STAIMAN 9:35 AT AUGUST 15 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOUN DALTIMORE Wunder 1 Year | Wunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 1 M 2 □ F 078-26-4413 70 Director Sept. 10, 1929 POLAND Usual Residence of Decedeni 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND PIKESVILLE 288-7 BALTIMORE 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? ò 3 KESTREL LANE 21208 USA 238 Funeral Rema Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yas 2 📉 No If Yes, Give 1 Never Married 2 Married 8 1 ☐ Yes 2 ☐ No Specify: WHITE 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) PRODUCTION MANUFACTURER Maryland 17 Father's Nama /First Middle Last 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be ISAAC STAIMAN RUTH HALPERN 19a, informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a till learn 27 is or other tra GERALDINE STAIMAN (WIFE) 3 KESTREL LANE, PIKESVILLE, MD 21208 aftimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE CEMETERY 8/16/00 BALTIMORE, MARYLAND 21. Signature of Funeral Service I 22. Name and Address of Facility LOUDON PARK FUNERAL HOME 23a Past enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

A 23a Past enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate interval Between Onset and Death **Physician** /Medical Immediata Causa (Final SEPSIS disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the Due to (or as a consequence of): signed by the at d be detached for P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA Division of Vital Records, py 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? CONGESTIVE HEART FAILURE 1 Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

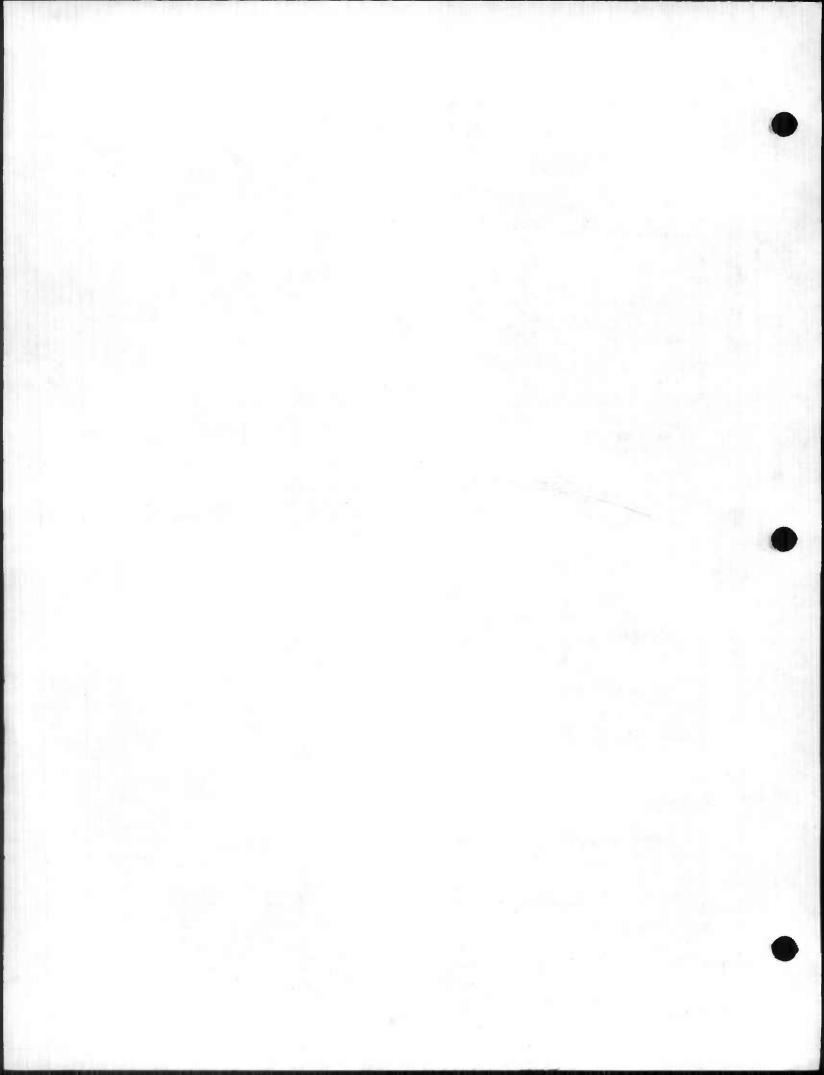
To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 25 No 28a. Dete of injury (Month, Dey Year) 27. Menner of Death 28b. Time of injury 28c. injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar 19.5. RAO. TO 043462 AUGUST 15, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 . 3 . RAO. M. O. MORTHWEST HOSPITAL CENTER RANDALLSTOWN, & O 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

AUG 1 7 2000



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Physician /Medical Examiner

permit. Pagas 1 and 2 should be filed within 72 hours after daeth with the Marylend Department of Health and Mentel Hyglena. Important: If Itam 27 Is marked other than "natural", or itsms 23s or 28s-f show any injury or other traumatic event, the Medical Examines must be notified at once.

Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral Director

29a. Certifier

Directo

Funeral

à

Completed

Be

To

Examiner

Physician/Medicai

Be Completed by

10

Certification:

physician and s the burial-transit 98 esn ed by the attent dateched for u

Antar this cartificate has been signed by funeral director, page 2 should be dated

The law requires that the death certificate be executed To the Hospital or Attending Physician: Tha law within 24 hours after daath. To the Funerel Director: Aftar this carificete hes complately filled in by the

Division of Vital Records, P.O. Box 68760,

Medical 29b. Signature and ting

FIRST YEAR RESIDENT

29c. Licanse numbar P13470

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, deta end place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of exeminetion end/or invastigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Year) AUGUST 16, 2000

30. Nama and addrass of person who completed causa of daath (Item 23e) (Type, Print)

MOHAMMED ALATTAR

3001 SOUTH HANOVER ST., BALTIMORE, MD. 21225

AUG 1 7 2000 State Registrar

32. Registrar's Signatura

ALLEGATER F FRANCES

CHESTING HEATT FALLONG

THE STAR STARTER

Amended It	.cem#23a perPHYG786 8/17/	State of Marylar 2000 EW		ment of H			giene leg. No. 0 (26008					
Physician /Medical	1. Decedent's Name (First, Middle, La. Margaret Swi	f+				2. Date of Dea Month	Day 12 20	ear 1:12 AM					
Examiner	Vniversity of Mary	a street and number)	ester	4	b. City, Town, or Lo Baltimo			N/A					
Funeral Director	5. Social Security Number 218–18–0203 6. S		last birthday)	f Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Da) Nov. 25	, Year) 9	Birthplace (State or Foreign Country) MD					
And and	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Locat				10d. Inside City Limits						
r 28a-f show notified at rector	MD	VA .	Ba	ltimore C	ity		TOYes 2□No						
fler death with the Ma fler them 23s or 28s-f s diner must be notified Funeral Director	1343 Hull Street			10f. Zip Code	21230		10g. Citizen of What Country? United States						
at, or hams Example in	11. Marital Status 1 Never Married 2 Married 30XWidowed 4 Divorced	12. Was Decedant Evar in L Armed Forces? 1 Yes 2 Polo If Yes, Give Year or Dates:	If Y	s Decedent of H es, specify Cuba Yas 2XXNo	ispenic Origin? (Spe n, Mexicen, Puarto Specify:	acify Yas or No- Rican, atc.)		American Indian, White, etc. White					
ad within 72 ho yglene. we than 'neturn it, the Medical.	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give kin life. DO	t's Usual Occupi d of work done of NOT use retired	turina most of worki	ing	16b. Kind of Busin	Hame					
E 101 0	17. Father's Name (First, Middle, Last) Louis Dubiel				18. Mother's Name Magdaler			23/11/1					
CONL	19a. Informant's Name/Relationship (Theresa Purser / D				end Number or Rura Ley Drive, I			_					
armit. Pages 1 and Separtment of Health reportant: if lean 27 any Injury or other b BISS.	20a. Method of Disposition 1. ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	Place of Dispositi cemetery, cremet oly Cross (ory or other place		Date 14, 2000	20c. Location - Ci	ny or Town, State					
permit. Pa Department Important: any Injury ance.	4 Donation 5 Other (Specify) Holy Cross Cemetery August 14, 2000 Baltimore Maryland 21. Signature of Funcional Func												
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Basal ganglia hamorrhage Due to (or as a consequence of):												
executed in and itel-transit		b. HYPERTENSION											
the bur	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
death d for u	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death?						
igned by the be detached by Physis								□ Probably 4 □ Unknow					
been s should						24a. Was perto	an autopsy med?	24b. Were autopsy findings available prior to completion of causa of death?					
						101	es 20No	1□Yes 2□No					
Thysician: This certificated director, program To Be C	25. Was case referred to medical axaminer?	Hospital:		3□ DOA Oth	26. Place of Death								
수 등을 누	1 Yes 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injur	4 LI Marsing no		lence 6 Other now injury occurred						
8 2 2 2	3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street	, factory, office		28f. Location (5 City or Tox	Street and Number m, State)	or Rurel Route Number,					
Hospi 24 hour Funer Hely fil	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best of my knowiner: On the basis of examination and mannar stated.	owledge, death or ation and/or inves	ccurred at the tin tigation, in my o	ne, date and place, pinion, death occurr	and due to the e	cause(s) and manr date and place, an	er as stated. d due to the cause(s)					
To the vithin To the comple	29b. Signature and title of certifier	2		29c. Licens				Month, Day, Yaar)					
α	1	MO		P12	446		August	12, 2000					
10	30. Name and address of person who	22 South Gres	ne St B	nt)	Mn 2	1201							
State Registrar	31. Date filed (Month, Dey, Year) AUG 17	32. Registrat s Sign	ature &	800	els								

II.u

26009 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Aug. 14, 2000 Margaret A. Savarese 3:05 p.m. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner 11107 Willow Bottom Drive Howard Columbia If Under 1 Year | If Under 24 Hrs. Months Days Houra Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗸 F 53 Yrs. April 9 1947 Director 305-50-9338 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or hame 23a or 28a-f show the Medical Examinar must be notified at MD Howard Columbia 1 Yes X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 11107 Willow Bottom Drive 21044 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 11. Merital Stetus Blad within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Teacher Education permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important if them 27 is marked any Injury or other to-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Robert Whitehead Margaret Hyland 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) P.O. Box 1113 Columbia, MD 21044 Pinchos L. Andreen 20a. Method of Disposition

XXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State Date Columbia Memorial Park 8/17/00 Columbia, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21 Sonature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045 ricetions that caused the feeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, are cause on each line. Approximate Interval Between Onset and Death 23a: Pert1. Enter the diseese, or an ahock, or heart failure. List on **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Ur genta OVATSAN 340> **Examiner** Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Undarlying Cause (Disease or Injury that Initiated evants resulting in death) Last Due to (or as a consequence of) 2 P.O. Box 68760, Physician/Medical Due to (or as a consequence of). Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown concer stage II Division of Vital Records, P 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2 No : After this certifical efuneral director, p or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yea 2 No 10 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. fnjury at Work? Certification: 1 Natural 2 Accident 5 Pending after death.
I Director: After in by the furnishment 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Director Completely filled in b 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as atlated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 030573 8-15-0

31/s

Registrar

31. Date filed (Month, Day, Year)

AUG 1 7 2000

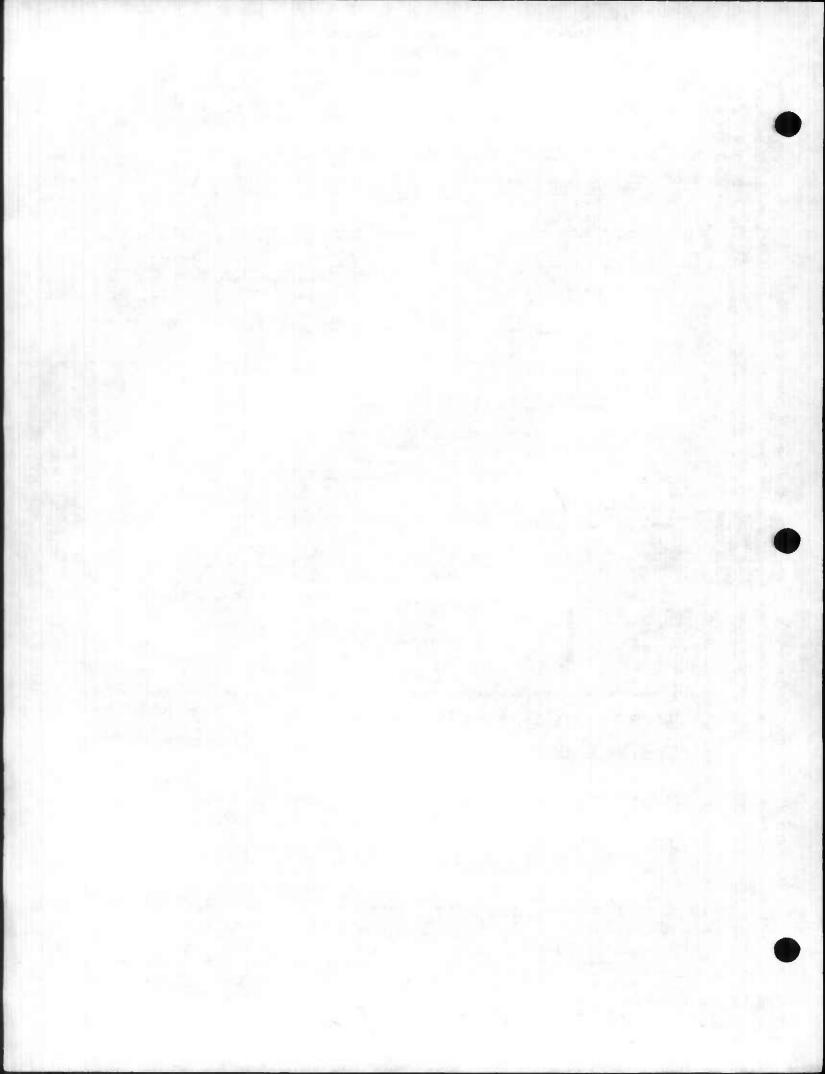
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

B. Spark

Paterint Pankway Columbia MO 21044

DHMH 16 Ray 6/95



				0	Cenii	ficate of	Death		Reg. No.	0 260	710	
Physician	100000000000000000000000000000000000000	ne (First, Middle, La	***					2. Date of De		000 10:=	a of Death	
/Medical	KOSE MO	rie Sico	l ve street and number	el .			4h City Town or	Location of Deat		y of Death		
Examiner	Stella M		o sireet and number	Towson	Coolings of Dout		Etimore					
Funeral	5. Social Security	ear If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State of										
Director	215-10-3090 82 Trs. Aug. 22,1917 Max Usual Residance of Decedent									Marylan		
ms 23s or 28s-f show result to morned at	10a. State	10b. County		10c. City, T	Fown or Locati	ion				e City Limits		
ecto	MD	alk	10f. Zip Code			1 ☐ Yas 2						
D D	1619 Four	1619 Four Georges Court							USA	What Country?		
eral	11. Marital Status	oeonges	12. Was Decedent	t Ever in U.S.	13. Was	21222 s Decedent of	Hispanic Origin? (Specify Yes or No		ce - American India	n.	
th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 23s-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Armed Forcas? 1 Nevar Married 2 Married 1 Yes 2 M No If Yas, Giva Year or Dates:					Yes 2 No	Hispanic Origin? (ban, Mexican, Pue	rto Rican, etc.)	Specif	ick, White, etc.		
	15. Decedent's Education (Specify only highast grade completed)				16a. Decedent	t's Usual Occu	upation e during most of w	ndkina	16b. Kind of B	Business/Industry		
	Elementary/Sec	5+)	iife. DO	NOT use retir	ed)	UKNIY						
	8	Homer	maker	10.00-0		Own H						
	17. Fathar's Name			Lucia C	ame (First, Middle	, warden Surnar	me)					
		Vincent Liberto 19a. Informant's Name/Relationship (Type, Print)					et and Number or F		er City or Town	State Zin Code)		
eith ar 27 is rr trau	- Committee of the Comm	THE PERSON NAMED IN COLUMN	****									
156	Frank J. Sica/Son 1700 Lynx Court, Bel Air, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or cometery, crematory or other place)										a .	
nt: If if	1 Burial 2	4 Donation 5 Other (Specify) Baltimore Washington Cr. 8/17/00 Laurel, Maryland										
Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee Mo-074/ 22. Name and Address of Facility Witzke Funeral Homes, Inc.										
den la participa de la partici	No 1	1630 Edmondson Avenue, Catonsville, MD 21228										
h	23a. Part1. Entar shock, or he	tha disease, or com art failura. List only	plications that cause one causa on each l	2	163	0 Edmoi	ndson Ave	enue, Car	tonsvill	Le, MD 212	228	
/Medical xaminer	tmmediata Causa disease or conditi resulting in death)	(Final on	Lemme	ad the daath. I	Do not entar th	0 Edmol	ndson Ave	enue, Car	tonsvill	Le, MD 212	228 mata Between	
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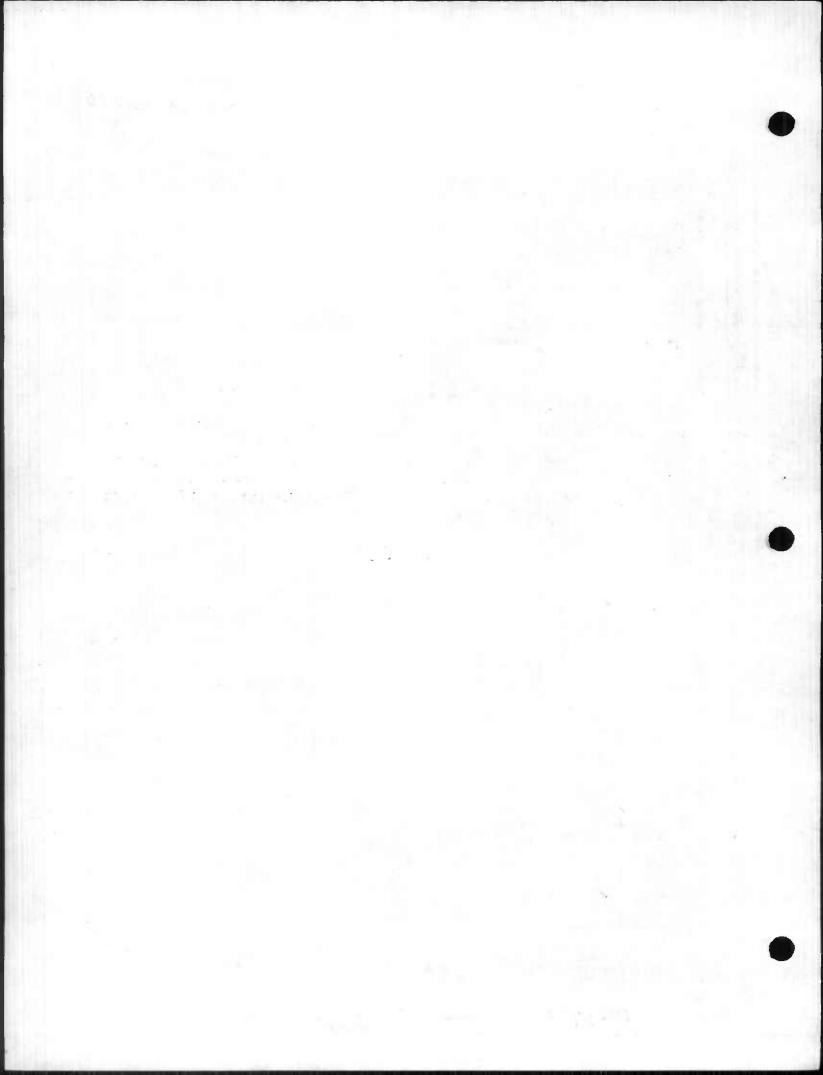
State Registrar

DHMH 16 Rev 6/95

AUG 1 7 2000

Bit-person & Sports

ORIGINAL



Please Type or Print In Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** THERESE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Year Birthplaca (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2♥ F Months Days Yrs 35 June 16, 1965 Louisanna Director 213-02-0369 Usual Residence of Decadent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 📉 No Director MD Howard Columbia Name 23a or 28a-f the Medical Examiner must be notifi-10f. Zip Code 10g. Citizen of What Country? 10a Street and Number USA 6298 Leafuscreen 21045 Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ĕ Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the Elementery/Secondery (0-12) College (1-4or 5+) Accounting Assistant Wholesale 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middla, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is merked of Floyd R. Spears Faylice Henry 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6298 Leafyscreen, Columbia, Maryland 21045 Faylice H. Spears/Mother Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 8/17/00 Clarksville. Maryland Witzke Funeral Homes, Inc. 22. Name and Address of Facility any le 5555 Twin Knolls Road, Columbia, Maryland 21045 July caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, 23a. Part 1-Enter the disease, or shock, or heert feilure. List Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequenca of): Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Sent Diabete Mellitus The law requires that the death certificate be execu Box 68760, P.O. | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Division of Vital Records, Medicai Certification: To Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas a No Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Menner of Death 28a. Date of Injury (Month, Day Yeer) 28d. Describe how Injury occurred 28c. Injury at Work? To the Hospital or Attending Natural 5 Pending investigation after death. 1 Yas 2 No the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end menner stated. 29a, Certifier (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certifia 29c. Licensa numbai 2000 cause of death (Item 23a) (Type, Print) larshall KNOLL

DHMH 16 Rev 6/95

State

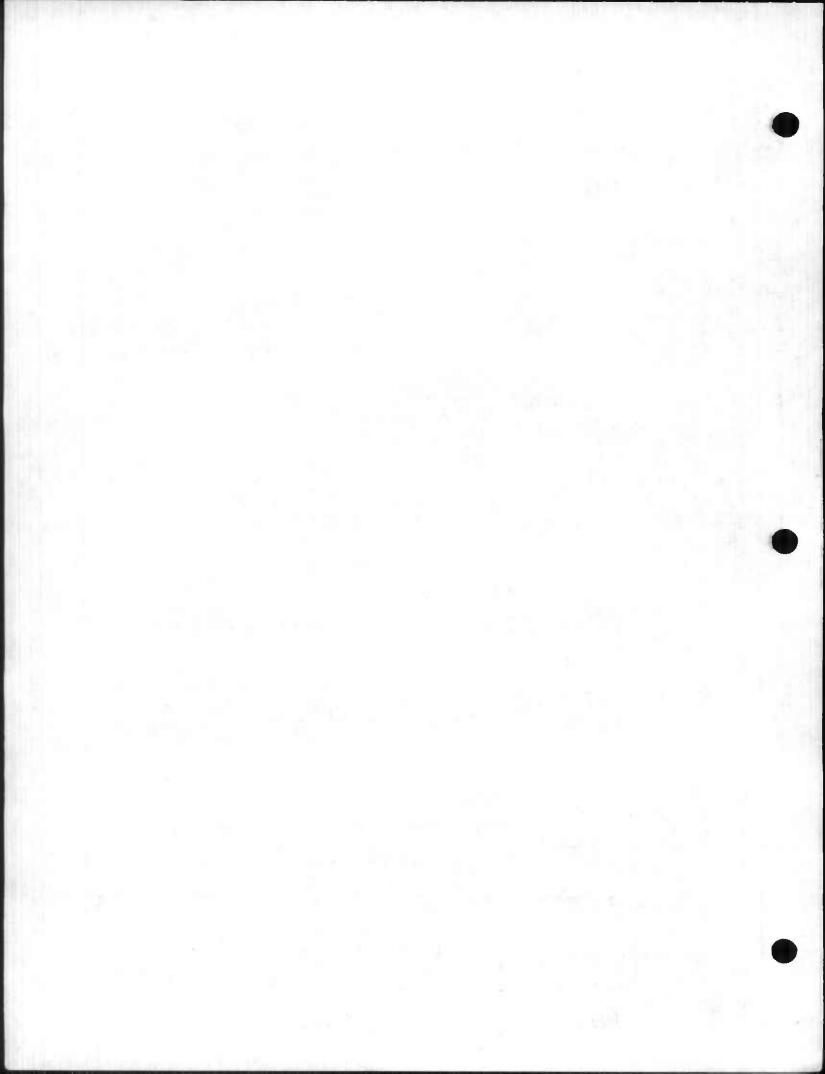
Registrar

31. Dete filed (Month, Day, Year)

AUG 17 2000

ORIGINAL

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Veer EDITH W. SCHULTZE AUGUST 2:30 PM 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth PARKVILLE PERRING PARKWAY GENESIS ELDERCARE BALTIMORE COUNTY If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days 10 M 25 F 215-09-2668 92 JANUARY 20, 1908 MARYLAND Usuai Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND NA BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROAD 21239 1327 GLENDALE UNITED STATES OF AMERICA Raca - American Indian, Bieck, White, etc. 11 Merital Stetus 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL OFFICE EXECUTIVE SECRETARY 12TH GRADE N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH WUSTLAND URITH HARGEST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9926 FERNDALE AVENUE/ COLUMBIA, MARYLAND 21046 FRANCES BROCATO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 M Buriai 2 ☐ Cremation 3 ☐ Removal from State Aug. 17 200 BALTIMORE, MARYLAND PARKWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 6009 HARFORD ROAD Donald R. Watson ALTENBURG FUNERAL HOME, P.A. BALTIMORE, MD. 21214 h. #MC0612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finei disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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72 hours after

Hygiene

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21215-0020

altimore, Maryland

Physician/Medical Examiner Be Completed by

the should be Medical Certification: To

certificate To the Hospital or Attanding Physician: "
within 24 hours after death.

to the Funeral Director: After this certification physician by the funeral director; p

The law requires that the death certificate be axecuted

P.O. Box 68760,

Division of Vital Records,

25. Was case referred to madical axaminer? 1 Yes 27. Manner of Death

t PNatural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

26. Place of Death (Check only one)

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifie? 1 'CO coiD

29c. License number

小

29d. Date signed (Month, Day, Year)

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1 ☐ Yes 2 ₺No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G (2.4) ARTORD 040

31. Date filed (Month, Day, Year) State Registrar

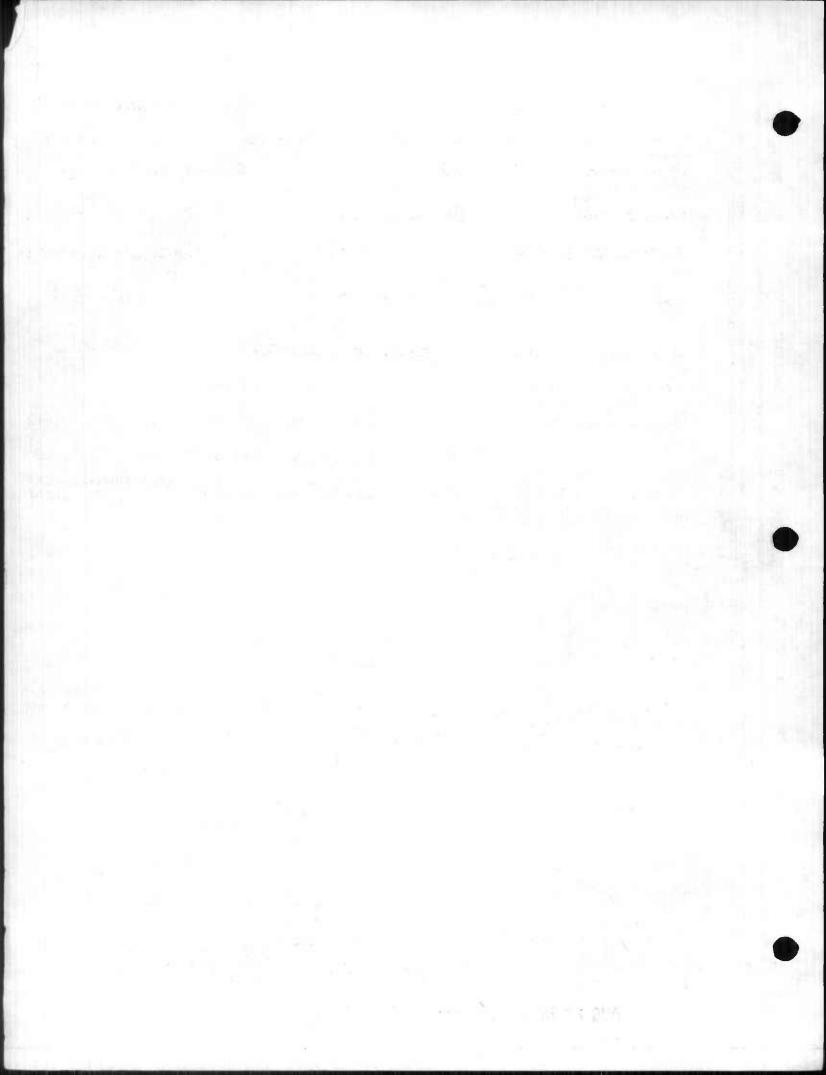
29a. Certifier

AUG 1 7 2000

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Date of Death 3. Time of Death В. Sala 2000 5:55 A.M. AUGUST 16 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth FRANKLIN SQUARE HOSPITAL CENTER KOSEDALE BALTIMORE 8. Dete of Birth (Month, Day, Year) 13,1935 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country)
 M D 5. Social Security Number Months Deys Hours 1 M 2 KF 220-30-7203 64 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Rosedale 10f. Zip Code 10g. Citizen of What Country? 2005 Wintergreen Place 21237 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2√☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clothing cutter Clothing 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) L. Boyle Margaret 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4624 Forge Acres Dr., Perry Hall, MD Glenn Williams-son 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetton 5 ♥ Other (Specify) Entombment Moreland Mem'l Park 8/19/00 Baltimore, MD 21. Signeture of Funerel Sarvice Licensa William G. Dau 22. Name end Address of Fecility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one ceusa on aech line. Approximata Intervat Between Onset and Death tmmediete Cause (Final disease or condition resulting in deeth) MYOCARDIAL INFARCTION 15 MINUTES ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably WUnknown 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician/Medical Examiner

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Be Completed

Medical Certification: To

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page 2 should

After this the funeral

after death

within 24 hours a To the Funeral C

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Health Sem 27

Pages

The law requires that the death certificate be executed

Box 68760,

P.O. |

Records,

of Vital

Division

To the Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

8

Maryland 2 should be and Mental

Baltimore,

Vera

10e. Street and Number

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10a. State

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Sequentiatly list conditions, if any, laading to immediate cause. Enter Underlying Cause (Dissess or injury that Initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

lutur

CONGESTIVE HEART FAILURE

1 Yes 2 No 26. Piece of Death (Check only one)

25. Wes case referred to medicat 1 Yes 2 No

27. Menner of Death

1 Naturel

2 Accident

3 Suicide

29a, Certifiar

4 Homicide

5 Pending investigation

28a. Dete of Injury (Month, Day Year) 6 Could not be determined

Hospital: 1 Monpatiant 2 ER/Outpatient 3 DOA

Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta end place, and due to the ceuse(s) end menner as stated

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, deta and place, and dua to the causa(s) end manner steted.

29b. Signature and title of certifier

29c. License number D31008

29d. Dete signed (Month, Dey, Year) 8-16-00

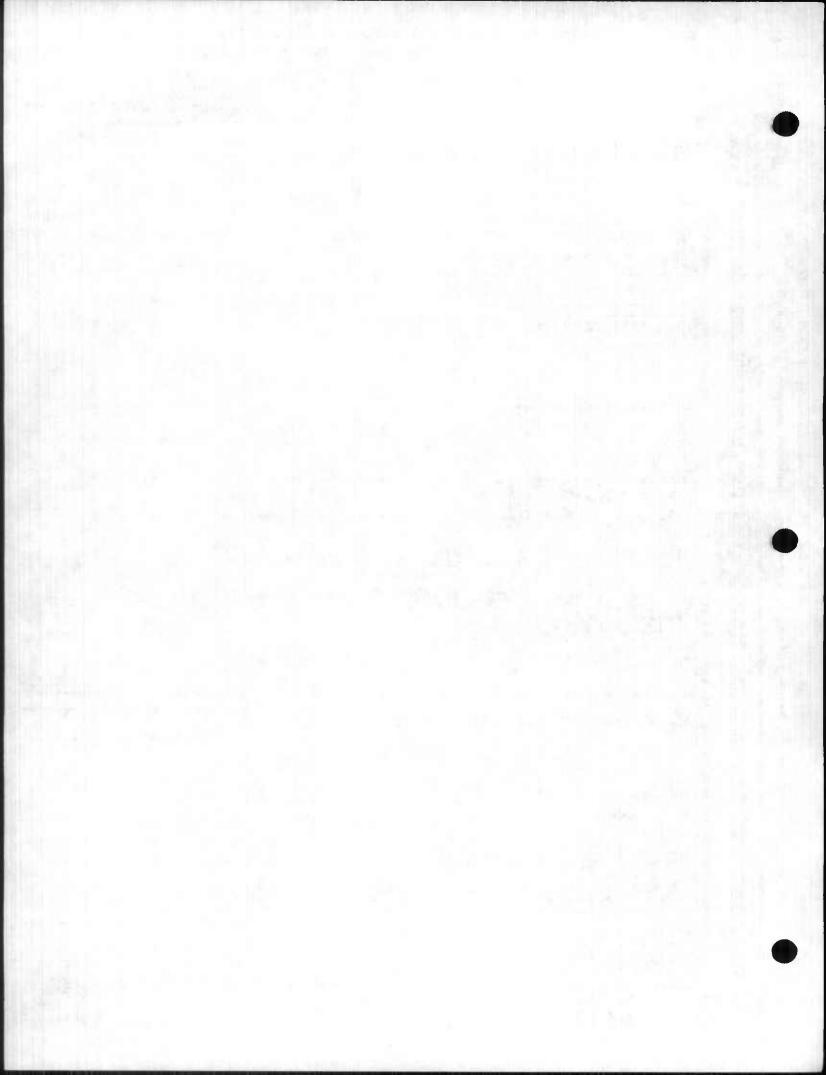
30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print)

9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237 DAVID PETCHERT, MD, 31. Date filed (Month, Day, Year)

State Registrar

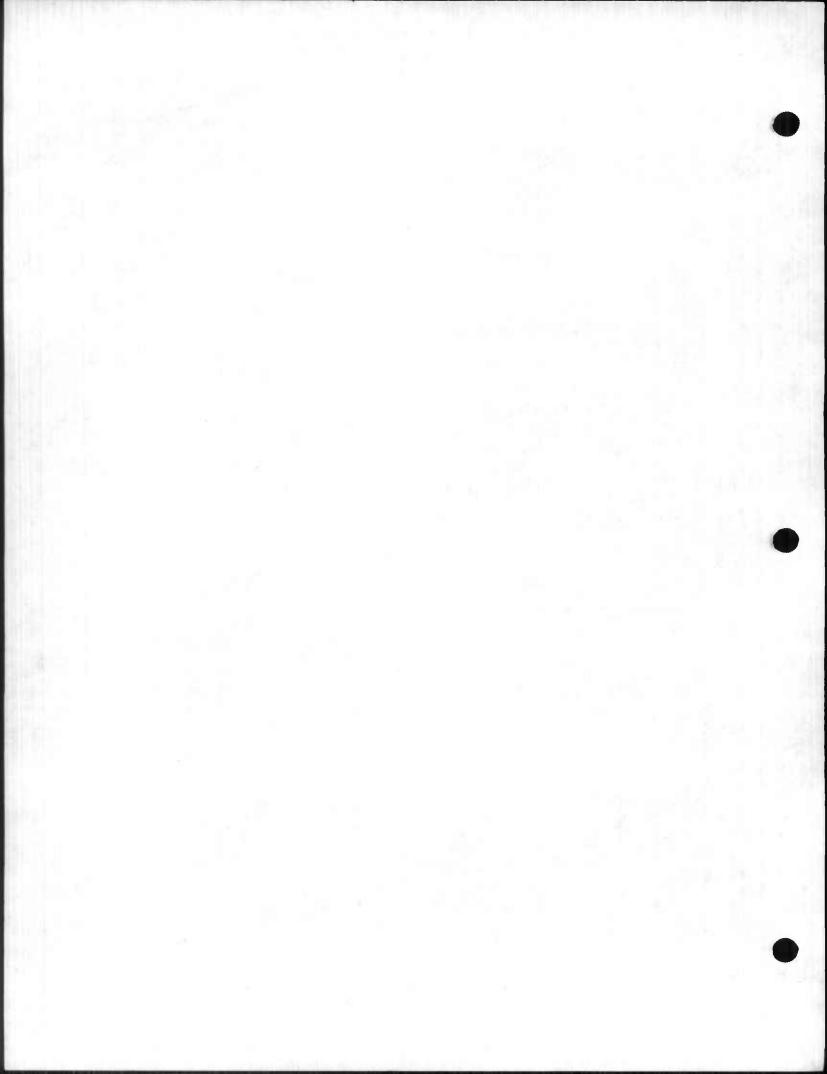
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32. Registrar's Signeture porks



State of Maryland / Department of Health and Mental Hygiene 00 26014

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d d	4 Donation 5 Other (Specify) Metro Crematory Inc. 8-14-00 Baltimore, MI 21. Signature of Funeral Service (Specify) 22. Name and Address of Fecility Cremation Society of MD, Inc.													
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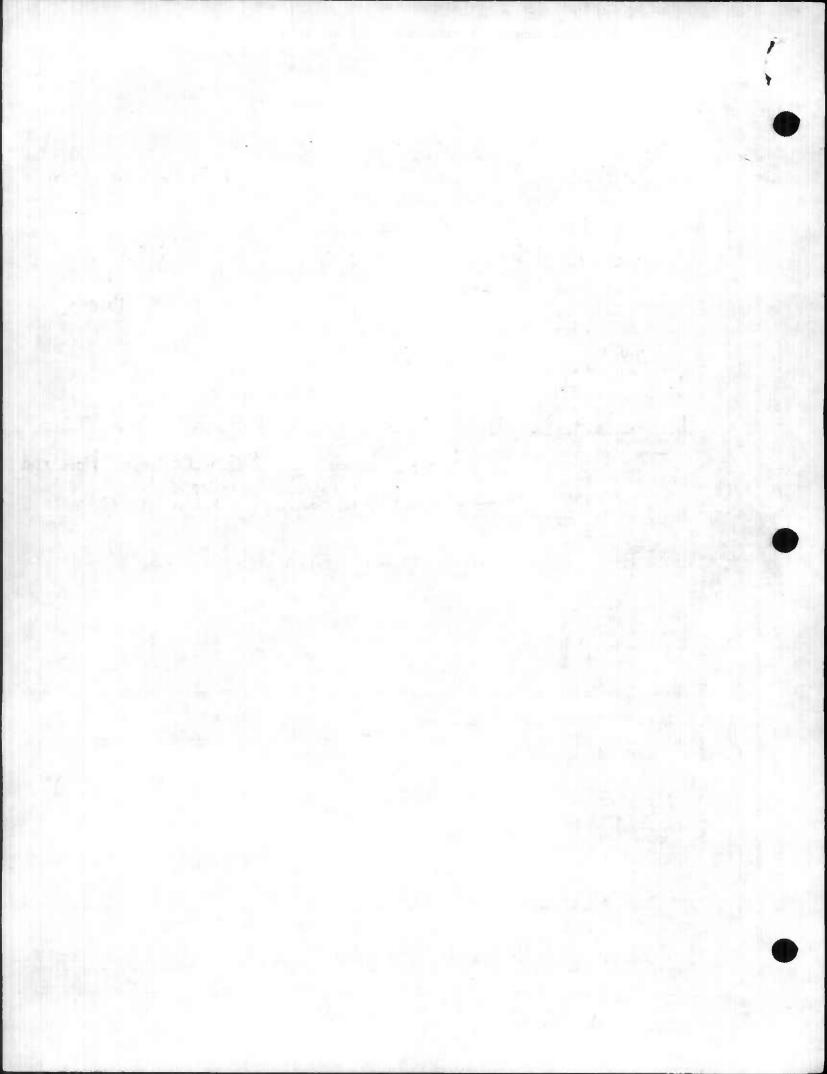


Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day **Physician** August ara 16 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner If Under Months Birthplace (State or Foreign Country) **Funeral** 10 W 20 F Days Min 220 - 30 - 49 50 Usual Residence of Decedent Yrs. Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or hems 23s or 28a-f show treumstic avant, the Medical Exeminer must be notified at TUYes 2 No Director 1d. altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2228 tree Funerai 14. Raca - Amarican Indian, Black, White, etc. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after if Hygiena.

other than "netural", or its 1 Never Married 2 Married 1 ☐ Yes 2☐ No If Yes, Give Year or Datas: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced ack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Thunderbird Elementary/Secondary (0-12) College (1-4or 5+) (04) 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file.
Department of Health and Mental Ly.
Important: if Item 27 is marked oth
any Injury or other traumatic avant
ang Injury or other traumatic avant Be Willie 2 locence Milliams 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of camefery, crematory or other place) Mexine Date 20c. Location - City or Town, Stata Smith - Noughter 20a. Method of Disposition 1-Buriel 2 □ Cremation 3 □ Removal from State 8-19-200 Beltimere. Genetery 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Miller's Metropolitan 1639 N. Broadure Approximate Interval Between Onsat and Death 23e, Part/. Ente/ the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Cause (Final disaase or condition resulting in death) Herniation 15 hours Examiner Due to (or as a consequenca of): Examiner 48 hours bdural hematomo been signed by the attanding physician and should be datached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Unemia P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed Thoracic nuntured has 2 No 1 Yes 20 No 1 Yas ancyrysm 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 1 Natural 5 Pending death. 1 Yes 2 No after death Director: A 2 ☐ Accident investigation 3 Suicida 6 Could not be determined 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homleide To the Hospital o within 24 hours of To the Funeral D completely filled in 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

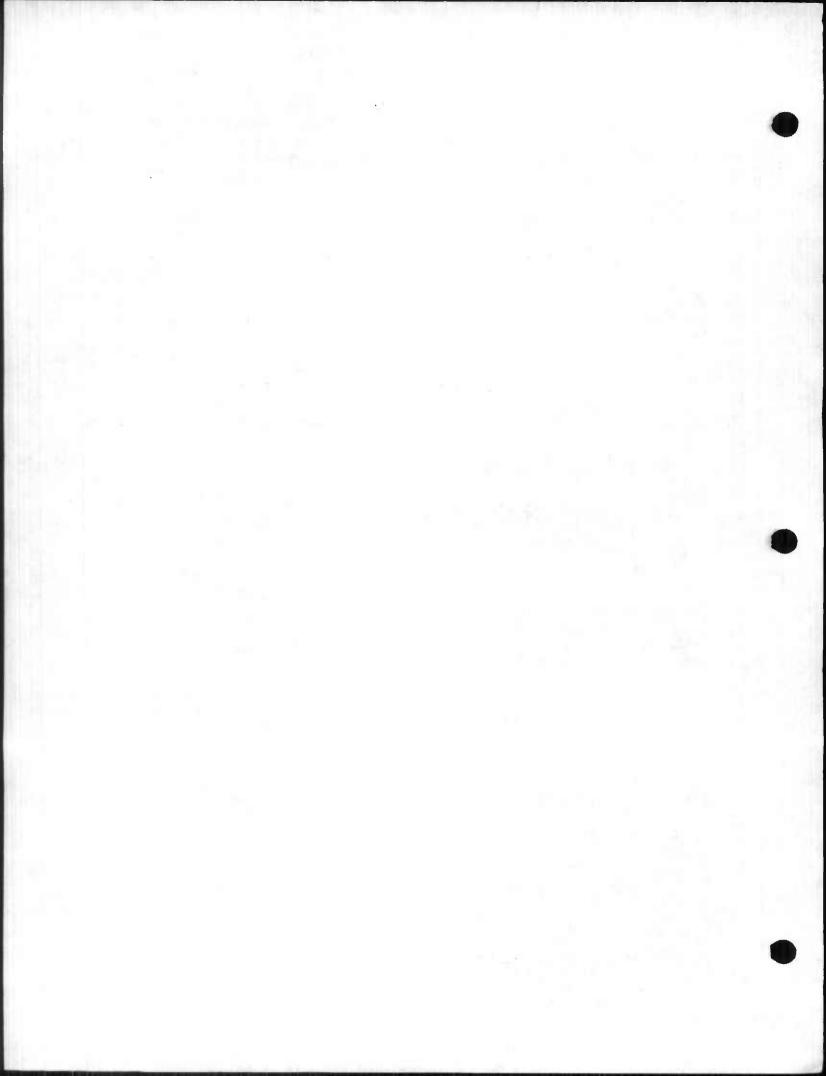
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-001 Hugust MO 16 2000 gan 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Wolfe Street Baltimore MD 21287-9106 Yorth an 666 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks AUG 1 7 2000 > Registrar

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State of Maryland / Department of Health and Mental Hygiene

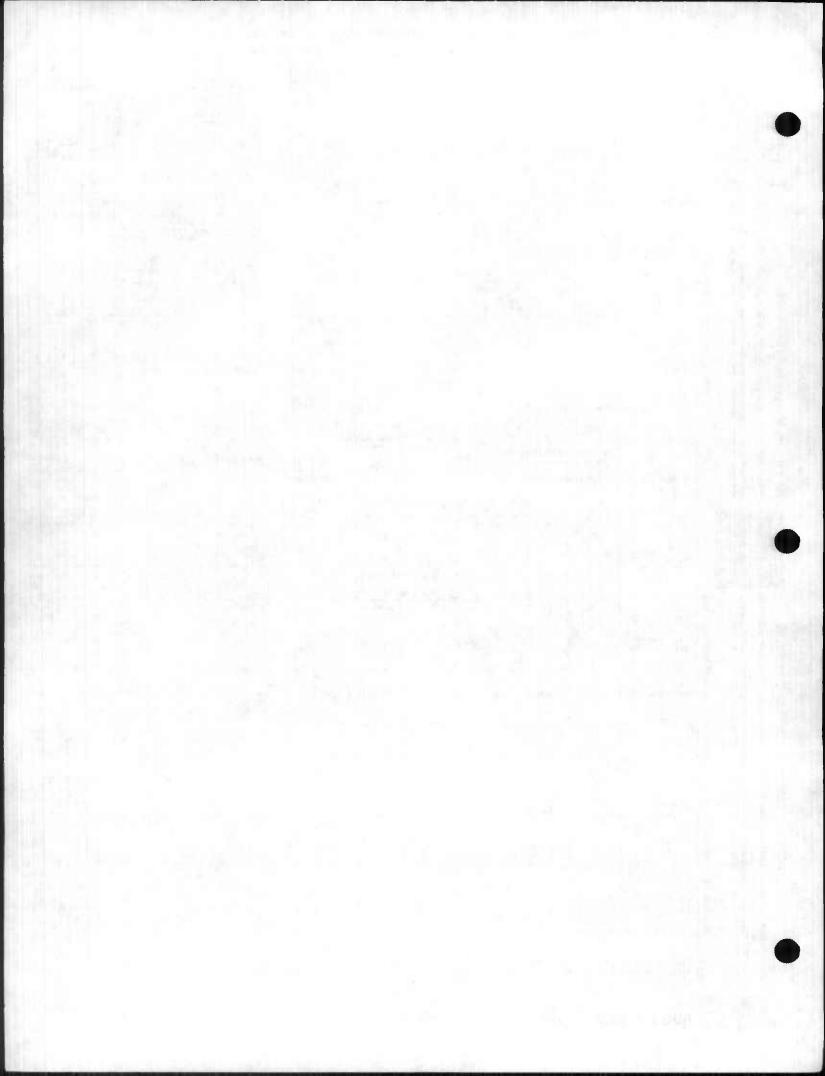
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o the	by E	11. Marital Status 1. Never Married 2. 3. Widowed 4. Divo	If Yes Give	es? XNo	13. Was Decedar If Yes, specify			as or No- etc.)		k, White,	ean Indian, etc. nite			
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la be	atic aver		Joseph L.	Scanlon				I. Bu						
(F)	la mar	19a. Informant's Name/Rela	ionship (Type, Print)	198	o. Mailing Address (S	itreet end Numb	er or Rurel Rout	e Number, C	City or Town,	Stete, Zip	Code)			
6 =	or tra	Lilia Tharp	/ Mother	1	6 Fourth	Avenue S	S.W. G1				land 21061			
Pages	- 1	20a. Method of Disposition 1 XBurial 2 Cremat 4 Donation 5 Other	ion 3 □Removal from Stor (Specify)	came <i>t</i> e	t Disposition (Neme ry, cremetory or othe Hill Cem	r pleca)	8/17		c. Location · Baltim		Maryland			
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/Me Exa	sician edical miner	23a/Part. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	a	MET	HANDONE consequence of):				H		Interval Between Onset and Death			
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To the Hospital within 24 hours	pletely file		ifying Physician: To the be ical Examiner: On the basi and manne	s of examination ar										
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	1	30 Name and address of an	son who completed cause	of death (Item 33a)	(Type Print)	O.C.M.	E.		Augu	ıst 1	.5. 2000			
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State of Maryland / Department of Health and Mental Hygiene

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	1. Decedent's Name (First, Middle, I	ast)			7.19		2. Date of D	eath Day	Year	3. Tima of Death		
Physician /Medical	Naomi S	nith					August 15 2000			07:57		
Examiner	4a Facility Name (If not institution, g	ive street and number)		17-11-15	4	b. City, Town, or		th 4c. Count	of Death			
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Det D	1 Never Married 2 Married	Armed Forces?		If Yes, sp	ecify Cuba	n, Mexican, Puè	(Specify Yes or No- lerto Rican, etc.) 14. Race - Ameri Black, White			etc.		
by F		If Yes, Give	1 ☐ Yes 2 🖾 No Specify:			Specify:		Specia	y: Wh	nite		
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Be eve	17. Father's Name (First, Middle, La								faiden Su <i>m</i> ame)			
To To		John Doffmy					lary Pea					
	19a, Informant's Name/Relationship						lural Route Num	ber, City or Town	, State, Zip	Code)		
# tr	Ruth Ingrassia	/ Daughter		4 Popla			Glen Bu	rnie, Ma	ryla	nd 21061		
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	23a. Part1. Enter the disease, but a shock, or heart failure.	plications that caused	the death. Do no	ot enter the mo	de of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between		
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	30. Name and address of person wh	o completed squee of d	anth (Item 22a) C	Type Print)	1100	,		MUSUST		2000		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 1.35 pm James Frank Sadler, Sr. AU GUST 4e Facility Neme (If not institution, give street and mu 4b. City. Town, or Location of Death 4c. County of Death DSDITOU salk more Hanes If Under 24 Hrs. If Under 1 Ye Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1₺M 2□ F 213-34-4990 May 23, 1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yas 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3527 Old Frederick Road 21229 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ② No Specify White Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 8th College (1-4or 5+) Maintenance Mechanic Glass Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumerne) John Sadler Mollie A. Schalitzsky 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 3527 Old Frederick Road Baltimore, Md 21229 Mrs. Elaine R. Sadler (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date to Buriel 2 ☐ Cremetion 3 ☐ Removel from State Loudon Park Cemetery 8/15 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenti 32 Name and Address of Facility Sterring - Ashton - Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, Md 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Pancreatic 1 ancer Knogressive 4 months Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es a consequence of): IWell egalnu Urann Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es a consedúenca of) Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 X No 1 □ Yes 2 □ No 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 X Neturet 5 Pending investigation 1 Yes 2 No 2 Accident

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29b. Signeture and bille of certifie

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Baltimore, Maryland

Juneral To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the I

State Registrar

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28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number 13596

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Dete filed (Month, Day, Year) AUG 1 7 32. Registrar's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Year Month TAVENNER EDWARD 15,2000 11:15 AM AUGUST 4s Fscility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTONA BALTIMORE Hours Min. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (Stele or Foreign Country) Months 1 X M 2 □ F 212-07-1650 August 20, 1904 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5510 Old Frederick Road 21229 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Yes, Give Specify: 3 ₩idowed 4 Divorced Yeer or Detes: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing 3 Pressman 17. Fsther's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) unobtainable Agnes Twamley 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5510 Old Frederick Road, Baltimore, Maryland 21229 Anthony Evans-Friend 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 8-16-00 Baltimore, Maryland Loudon Park Cemetery 22. Name and Address of Fecility Loudon Park Funeral Home 21. Signeture of Funerel Service Licensia usi S 3620 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel CHRONIC OBSTRUCTIVE PULTONAR. disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 况 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1万 Inpatient 2 ☐ ER/Outpalient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

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21215-0020

Baltimore, Maryland

Box 68760,

Division of Vital Records, P.O.

Directo

Funeral

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Completed

Examiner Physician/Medical the signed by d þ Completed certificate funeral director, Be Certification: To this Affer

The law requires that the death certificate be axecuted Attending Physician: or after death. Hospital 24 hours 24 hours Fumeral To the Hosy within 24 to To the Fun completery

Registrar

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6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier

28c. Injury at Work?

K.S.RAO.7.0

28a. Date of Injury (Month, Day Year)

1 Yes 2 No

043462 AUGUST 15,2000

28d. Describe how injury occurred

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)) . S. NA c. N. O.

28b. Time of

14 OS PITAL CENTER RANDALLS.70WN,

132. Registrer's Signature NORTHWEST

AUG 1 7 2000

27. Manner of Death

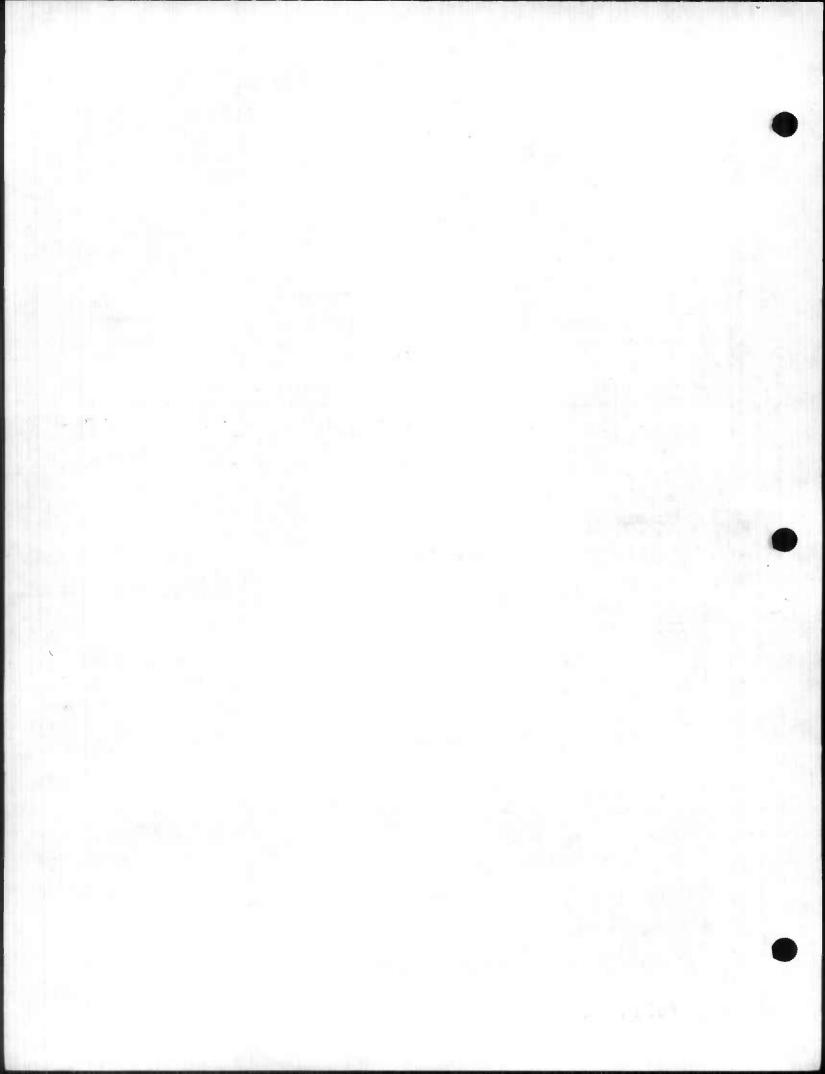
1 Netural

2 Accident

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5 Pending investigation

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month Year Patricia Trainor AUGUST 14,2000 8:10 pm 4a Facility Neme (Il not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth STREET 3201 FLEET BALTIMORE Hours Min. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months 10 M 2K) F 63 24,1936 VIRGINIA 231-42-5963 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits XXYes 2□No N/A BALTIMORE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3201 FLEET STREET 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Xoo If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 ASSEMBLY LINE MARYLAND CUP 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) THOMAS H. CREASEMAN BONNIE EDGE 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES W. TRAINOR/HUSBAND 3201 FLEET ST. APT. A, BALTIMORE, MD. 21224 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel Irom Stete 4 Donetion 5 Other (Specify) GREENMOUNT CEMETERY 81/16/00 BALTIMORE, MARYLAND 22. Name and Address of Facility LILLY & ZEILER 21. Signeture of Funeral Service Licensee INC. FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. CONKLING STREET, BALTO., MD. 21224 Approximate Interval Between Onset and Deeth Monic Obstructive Pulnonary Discare 5 years Immediate Cause (Finel disease or condition resulting in death) ypothyvoidism irrhosis Due to (or es e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

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The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

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To the Hosp within 24 hou To the Fune completely fi

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Physician/Medical

Be Completed by

Certification: To

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Physician

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MD.

Funeral

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Director

Funeral

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filed within 72 hours after

21215-0020

Baltimore, Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner? 26. Placa of Death (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 BNatural 1 Yes 2 No 2 Accident 28l. Location (Street end Number or Rural Route Number, City or Town, Stefe) 6 Could not be 3 Suicide Plece of Injury - At home, Ierm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Secretifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated

29b. Signeture and title of certifier

29c. License number 29d. Dete signed (Month, Day, Year)

omas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Johns Hopkins Gerialnic

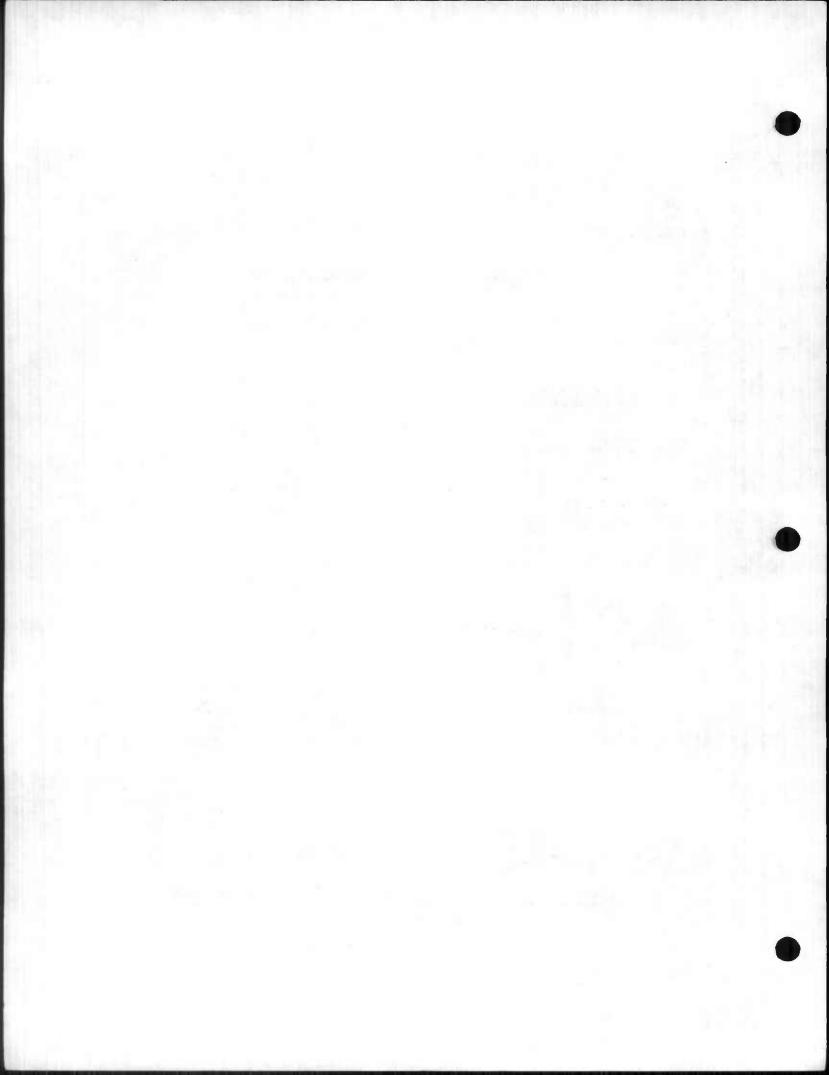
5505 HOPKINS Bayview Circle

State Registrar

31. Date lifed (Month, Day, Year)

32. Registrar's Signeture AUG 1 7 2000 00g 20 THEN A A AAAA

DHMH 16 Rev 6/95

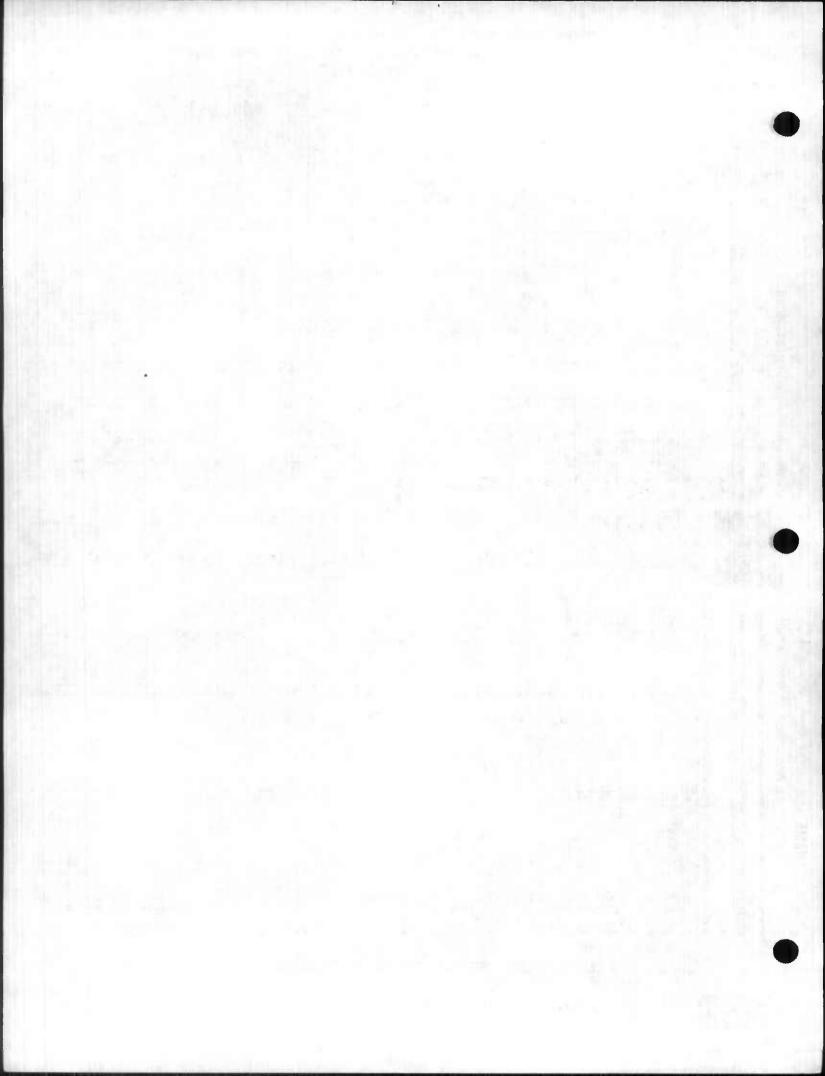


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State of Maryland / Department of Health and Mental Hygiene

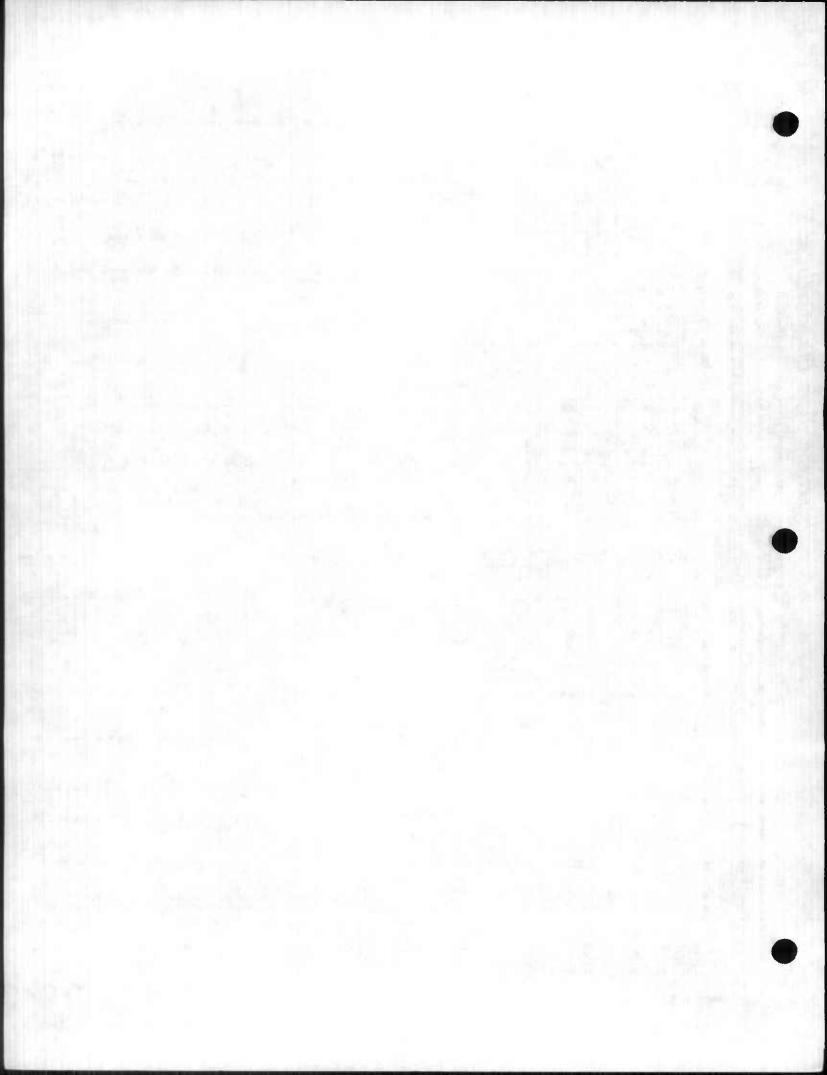
partment of Health and Mental Hygiene ertificate of Death Reg. No. 26021

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1111	Examin	ei.	St. Hanes	1/	soit	1				Ral	tin	m		N/A		
		-		6. Sex	7.4	ge (In vrs.	last birthda	y) If Und	der 1 Yeer	If Under	24 Hrs.	8. Date of Bi	rth		nplace (State or F	oreign
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	splus noun	la l	29a. Certifier 1☑ Certifying	Physicia	n: To the bes	it of my kno	wiedge, de	ath occurre	ed at the tir	me, date ar	nd place,	and due to the	cause(s) and r	nanner as	stated.	
	Pu Fu	Medical Certification:	(Check only 2 Medical E		On the basis and manner :		ation and/or	investigati	ion, in my o	pinlon, dea	ath occur	rred at the time	, date and place	, and due	to the cause(s)	
	To the Hospital or Attending Physician: The law requiras that the death cerwithin 24 hours after death. To the Funeral Director: After this certificata has been signed by the attendin completaly filled in by the funeral director, page 2 should be detached for use	Me	29b. Signature and title of certifier	D	EDICA	LRE	SIPEN	T 2	29c. Licens	se number			29d. Date sign	ed (Mont	h, Day, Year)	100
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7	Stat	te	31. Date filed (Month, Day, Year)	60	32 Regis	trars Signe	eture	1-700								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** 13, Kenneth Arden Willaman AUG 2000 6:43pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) JUNE 19, 1 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Deys ₩ 20 F 278-30-6187 65 Yrs. Ohio Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 812 Drohomer Place 21210 USA Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Nes 2 No 1958— If Yes, Give Yeer or Detes: 1961 10 1 Never Merried 2 Merried 1 ☐ Yes 2 → No þ Specify: White 3 Widowed 4 Divorced 1961 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cottege (1-4or 5+) 5+ Cellist Orchestra 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 2 should be f and Mental h Kenneth Willaman Helen Burdine Rabel 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum 19a. Informent's Neme/Retetionship (Type, Print) Stephen W. Fisher/companion Baltimore, MD 21210 Dete 20c. Location - City or Town, Stete 812 Drohomer Place 20e. Method of Disposition 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete 20b. Place of Disposition (Name of cemetery, cremetory or other place) Metro Crematory, Inc. 8/14/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funerel Service Licenses Dawn F 299 Frederick Road Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Finet 18 months diseese or condition resulting in deeth) Examiner Due to (or es a consequence of) Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence ot): Due to (or es a consequence of): Box (23b. Did tobacco usa contributa to the causa of death? P.O. Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown of Vital Records. Completed by 24b. Were autopsy tindings 24e. Wes an autopsy performed? available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) MOSPICE Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edicai Certification: To 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Hospital or Attanding Division 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, ferm, street, tectory, office building, etc. (Specify) 4 ☐ HomicIde To the Hospital of within 24 hours at To the Funeral Completely filled 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signeture and the of continue 29d. Date signed (Month, Dey, Year) 29c. License number , mo cause of death from 23a) (Type, Print) N. Charles St. Balto. md 2,208 B 6 201 51. Dete filed (Month, Day, Year) 32. Registrer's Signeture State · come Registrar DHMH 16 Rav 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Day AUgust Month Year **Physician** Mary Frances Wilt 2000 15 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Fallston General Hospital Fallston Harford 8. Data of Birth Month, Day, Year) Jan. 21, 1926 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) VVGUNIA 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar **Funeral** Days 1□ M 2♥F Months Hours 230-24-9092 74 Director Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 Yas 2 No Director Fallston Maryland Harford 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21047 U.S.A. 1404 Terry Way 234 Funeral flems ? 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 Navar Married 2 Married 21215-0020 8 White 1 ☐ Yas 2 ☒ No Specify: Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Self-Employed Hygiene. Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Real Estate Real Estate Agent Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be nent of Heelth and Mental Zella Abshire Hollie B. Bowman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) Department of Heelth ar Important: If Item 27 is any injury or other trau Keathley Janet L. 3408 Gem Drive, Pueblo, Colorado (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 Cramation 3 Ramoval Irom Stata Dulaney Valley Mem'l Gar 8/19/00 Timonium, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Schimuner Funeral Home, Inc. 21. Signature of Funaral Sarvice Licenses 9705 Belair Rd., Baltimore, 21236 ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, hock, or heart lailure. List only one ceuse on each ine. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner week Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to lox as a consequence of) mont ? P.O. Box 68760, Irr lusis Physician/Medical Disease Parf II. Other algoriticant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No certificate Division of Vital 25. Was casa retarred to medical axeminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1- Natural 1 Tes 2 No death. 2 Accident after death 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, larm, street, factory, office building, atc. (Specify) 4 Homlcida 24 hours a completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) To the I 29b. Signatura and fittle of cod 29c. License number 29dyData signed (Month, Day, Year)

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30. Nama and addrass of person

31. Data filed (Month, Day, Year)

AUG 1 7 2000

Registrar

DHMH 16 Rev 6/95

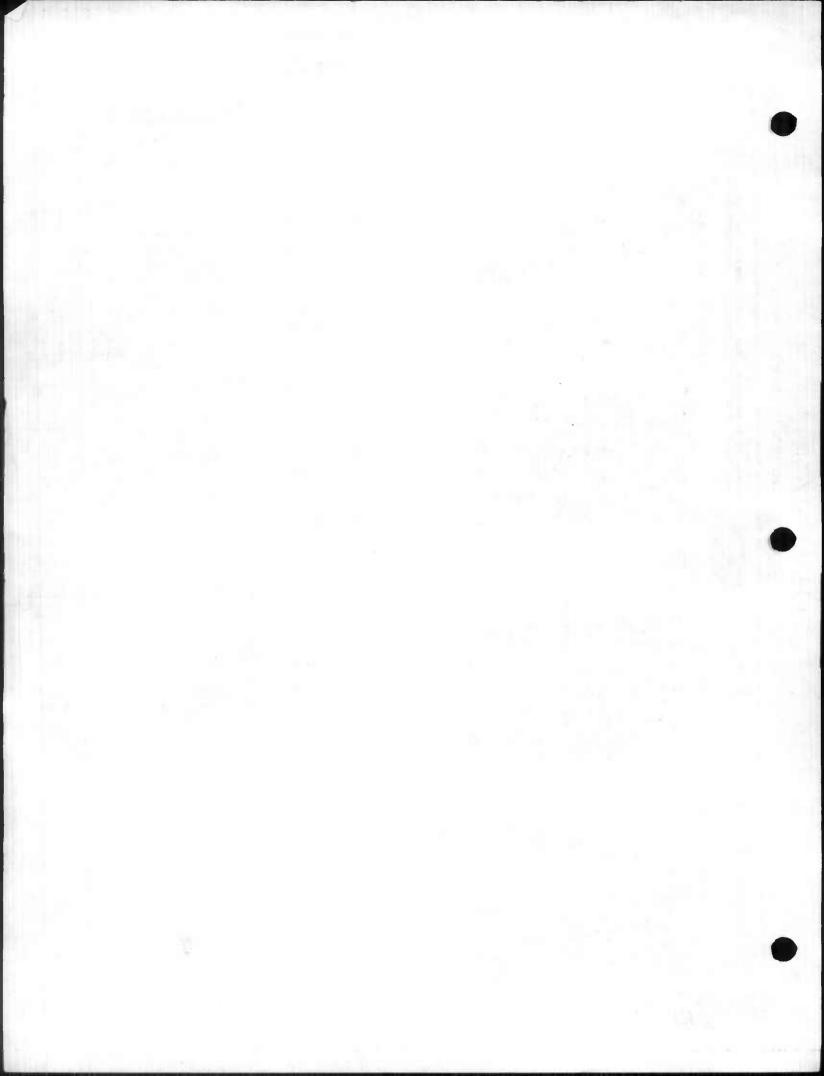
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who completed causa of death (Item 23a) (Type, Print)

32. Registrer's Signatura

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26024 Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Year **Physician** -EKRELL WILLLIAMS 0914 AM AUGUST 2000 /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner HOSPITAL CENTER RANDACL STOWN NORTHWEST BACTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sax 1 M 2□ F 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 249-32-1635 44GUST 22, 1926 Yrs. South Carolin Director Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltin 1 Nas 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10 Belvieu 422 Norma 23a 4.5. Funeral 12. Wes Decedent Ever in U,S.
Armed Forcas?
1 ∑Yes 2 ☐ No
If Yes, Give
Year or Detas: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuben, Maxican, Puarto Rican, atc.) 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2No Black Specify. Specify: 3 NVidowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada completed) Bethlehe permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than 1 any injury or other traumatic avent, me he any injury or other traumatic avent, me he phose. Elamentary/Secondary (0-12) Collega (1-4or 5+) NORKER 12th 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be Unknown unknown 2 19a. Intermant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stete, Zip Code) Son Belvieu Are Bacta mg. 21215 COKlei 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 Cremetion 3 Removal from Stata Arbutus mem. 22 fack 00 Arbutus 4 □ Donation 5 □ Othar (Specify) 21. Signatur to Funaral Servica Licensea Lewis T. 22. Nama and Addrass of Facility Lewis 45178 arkheights Balto. mg. 21215 are. 23a. Part1. Enter the diseasa, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellura. List only one cause in each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in deeth) /Medical Examiner bdomsol Physician/Medical Examin Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Ceuse (Diseasa or injury Dua to (or as a consequance ot): Dua to (or as e consequence of): that initiated evants rasulting in death) Last atheroslevosis occlusion iliac avter Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No vascu(av Records, 24b. Ware eutopsy findings available prior to Be Completed 24a. Wes an autopsy completion of cause of death? Yas 1 Yas 2□ No 2 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Wes casa ratarred to medical examinar? 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specity) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Division Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 Suicide 28e. Pleca of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 I Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) end manner steled.

State Registrar

31. Deta tiled (Month, Day, Year) AUG 1 7 2000

29b. Signature and title of partition

30. Nama and address of person v

V. DIXON KING

, JR, M) 5401 32. Registrar's Signature

29c. License number

D43453

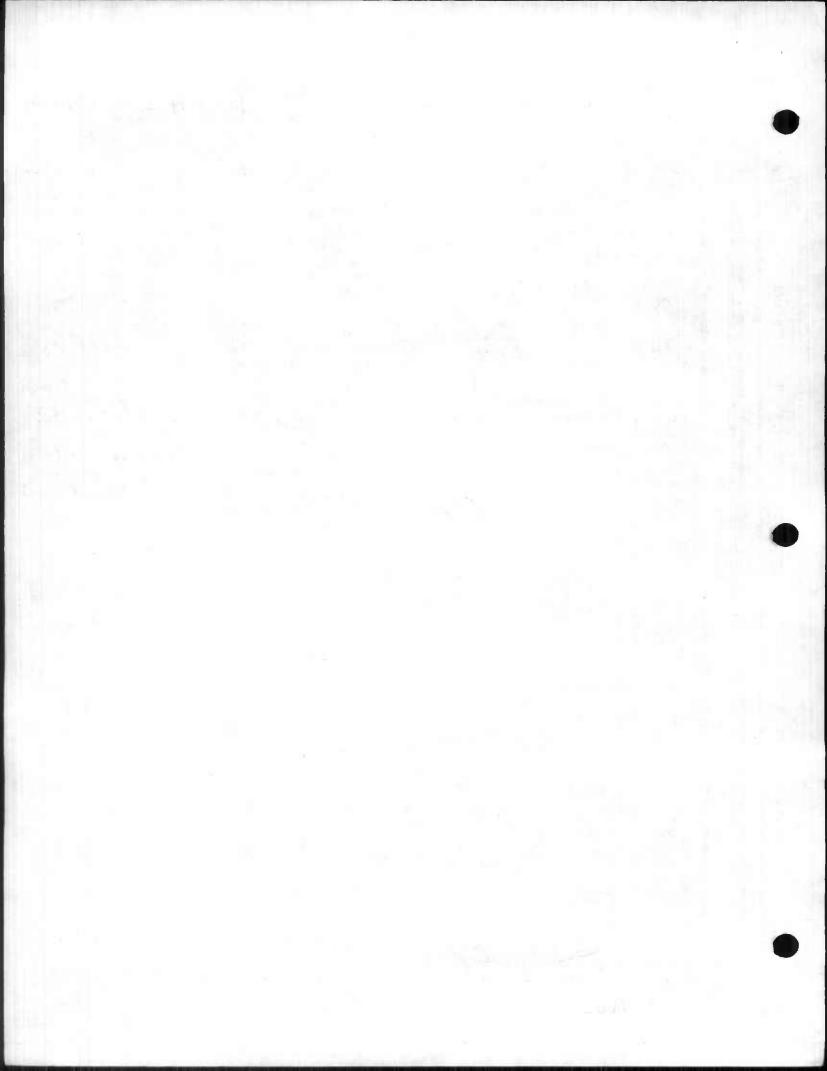
OUD COURT RD

29d. Dete signed (Month, Day, Year)

AUGUST 16, 2000

RANDAL (STOWN, MARYLANG)

(Type, Print)

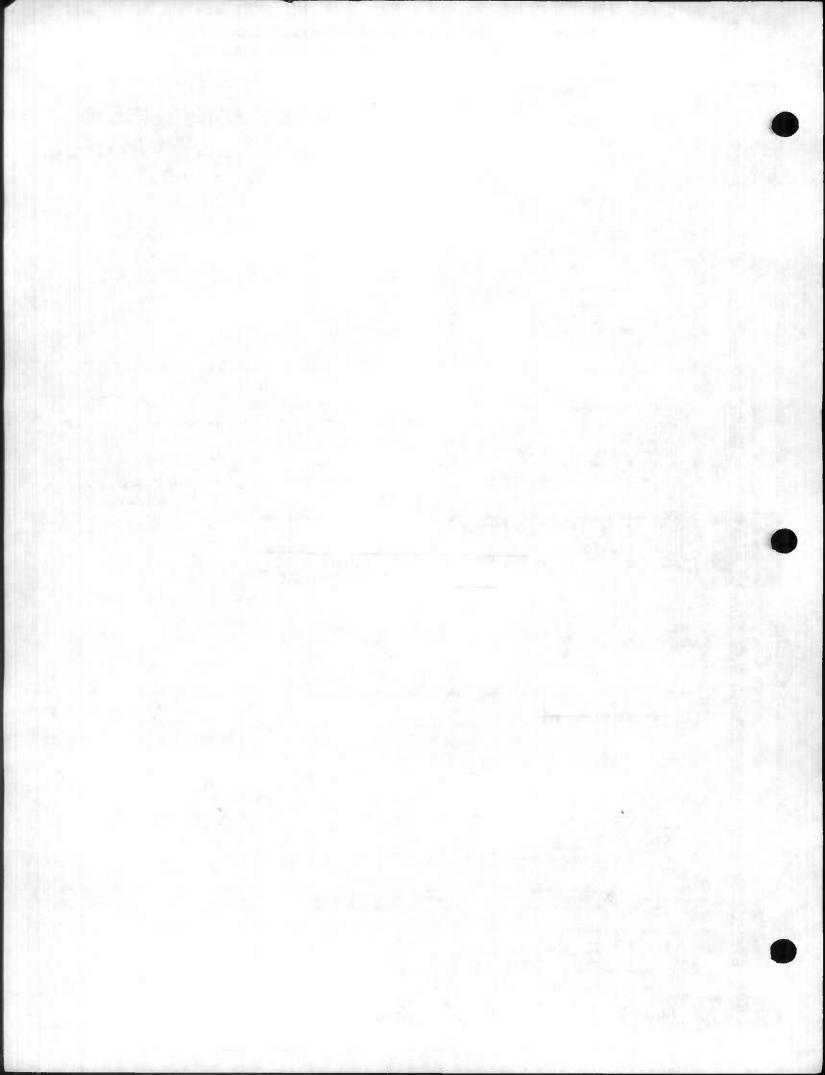


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

ysician	1.	TIEMS#23a,b,25&ptII Decedent's Name (First, Middla, Li		33	001		Death	2. Date of I	Reg. No.		26025
			Brenda	Carol V	Willh	nide		Augus Augus	Day	2000	6:00 A.M
Medical aminer	48	Facility Nama (If not institution, gi	ve street and number)				4b. City, To	wn, or Location of De		ounty of Death	
		5205 Brookwood	Road				Balt	imore	Ar	ne Arı	undel
		214 52 9734	Sex 7. Ag 1 □ M 2 1 F	ge (In yrs. last t 51	birthday) Yrs.	If Under 1 Yas Months Day		Min. (Month, I	30, 194	9. Birth Con Nort	hplace (Stata or Fore unity) th Carolin
	-	sual Rasidence of Decedant le. Stata 10b. County		10c. City, To	own or Loc	cation					10d. Insida City Limi
tor	M	Maryland Anne Ar	rundel	Balt	imor	e					1 □ Yas 200 N
ai Director		e. Street and Number 5205 Brookwood	Road			10f. Zip Coda 21	225			of What Co	untry?
by Funeral		. Marital Status 1 ☐ Nevar Married 213 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forcas 1 Tyes 2 If Yes, Giva Year or Datas:			Vas Decedent of Yes, specify Cu		pin? (Specify Yas or I , Puarto Rican, atc.)	No- 14.	nican Indian, a, etc. Mite	
Completed		15. Decedent's E (Specify only highast gr	ducation rada completed)	16	Sa. Deced	ent's Usual Occ kind of work don OO NOT usa reti	upation a during most	of working	16b. Kind	of Businass/I	Industry
du		Elamentery/Secondary (0-12) 9th	Collega (1-4or	5+)		00 NOT usa <i>retii</i> emaker	red)		O	wn Hom	2
		. Fathar'a Nama (First, Middle, Las	()				18. Mothe	r's Neme (First, Midd			
To Be			Allen Grub	b				Thelma H	offman		
		Pe. Informent's Name/Relationship Daniel Willhide				g Addrass (Stre		or or Rurel Route Num	-		ip Code) nd 21225
	20	a. Mathod of Disposition	7p	20b. Place cema	ot Dispos	sition (Nama of natory or other p	(aca)	Data	1	tion - City or	
		1 X Buriat 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special				1 Cemet		8/14/00	Balti	more,	Maryland
	21	1. Signature of Funaral Sarvice Cite	ensee	le		Nama and Add		Gonce ghway Bal	Funera timore		
	2	3a. Part1. Enter the disease, or con shock, or haart tailure. List only	nolications that cause	d the death. D	o not ante	ar the mode of d	ying, such as	cardiac or raspiratory	arrest,		Approximata Interval Between
	In	nmediata Causa (Final		RDIAC ARI			APPE	84		1	Onsat and Death
l .	ra	sulting In death)	a	Due to (or as		uanca of):OON	ESTIVE	CARDIOMYOPAT	нү	1	
I Examiner		equentiatly tist conditions, any, leading to immediate ause. Enter Underlying ause. (Disease or Injury	b	Dua to (or as		uanca of):					
VMedical	m	et initiated events sulting in death) Last	d	Dua to (or as	a consequ	uance of):					
	Pe	ert II. Other significant conditions	contributing to death t	out not resulting	g In the ur	ndariving causa	riven in Part I	23b. D	d tobacco us	e contribute	to the cause of dea
siciar			A						□ Yes 2 ⊅	(40 3□PI	robably 4 Unknown
y Physician/Med		FIRSTONIALE	. , ,							24b. 1	Wara autopsy finding
by	-	FIRROWHALL.						24a. W	as an autopsy rionned?		aveilable prior to completion of causa of death?
by	-	- PHREMIALE.						24a. W	as an autopsy normed?		completion of causa
Completed by		i. Was casa reterred to medical					26. Place	24a. W pe	formed? Yaa 2□I		completion of causa of death?
To Be Completed by	25	axaminar?	Hospital: 1 ☐ Inpati		Outpatien	1 3LI DOA	Other: 4□ Nu	of Deeth (Check only rsing Homa 5) Re	formed? Yaa 2□I y one) ssidanca 6 [No Other (Special	completion of causa of death?
To Be Completed by	25	axaminar? 1 Z Yea 2 No Negner of Death 1 Naturel 5 Pending 2 Accident investigetic	28a. Date of triple (Month, De	ury 28b	Outpatien Tima of Injury	28c. tn	Other: 4□ Nu	of Deeth (Check only rsing Homa 5) Re 28d. Describ	Yaa 2 ☐ I y one) sidanca 6 [e how injury c	No Other (Special Control of Cont	completion of causa of death?
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To Be Completed by	25 27 29	axaminar? 1	28a. Date of this (Month, De	jury - At homa, to. (Specify) of my knowled of axamination is	o. Tima of Injury tarm, stra	28c. tn W 1 aet, tactory, office occurred at that astigation, In my 29c. Lica	Other: 4 Nu	of Deeth (Check only rsing Homa 5 A Re 28d. Describ	Yaa 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No Other (Special Control of Special Control of Spe	completion of causa of death? I Yas 2 No city) ural Routa Number, s stated. I to the ceuse(s) h, Day, Year)

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26026 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Yaar **Physician** 2:10 AM Dorothy J. Wells 7000 Augus r /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Charlestown Care Center Catonsville Baltimore 5. Sociel Security Number if Under 1 Yeer if Under 24 Hrs. 8. Dete of Birth (Month, Dey, 02 13 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Deys Hours 214-40-5282 93 Yrs Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 26s-f show ther must be notified at 1 ¥Yes 2 □ No Director Md N/A Baltimore the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 40 Hamill Court 21210 USA death \ Completed by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status traumatic event, the Medical Examiner. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced white "natural", 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) College (1-4or 5+) Peges 1 and 2 should be filed within nent of Health end Mental Hygiene. int: If itam 27 is marked other than Teacher Balto. City Schools 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John Severn Wells Martha Elizabeth Henzler 10 19a. informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Health e If Itam 27 is or other tra James Ryan/Nephew 8 Rumford Drive, Suite 202 Catonsville, Md21228 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) 20c. Location - City or Town, Stete 1 ■ Buriei 2 Cremetion 3 Removel from Stete permit. Pege Depertment of Important: If any Injury or once. Lorraine Park 08 16 Baltimore, Maryland 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Sterling-Ashton-Schwab Funeral Home, Inc 23a. Pert1. Enter the distance, or complications that caused the daeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart allue. List only one cause on each line. Approximeta interval Between Onset and Deeth **Physician** /Medical immediate Cause (Finel Recurrent WEEKS neumonia disease or condition resulting In death) **Examiner** Due to (or es a consequence of). The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in death) Lest Due to (or es a consequence of): P.O. Box 68760, physician Physiclan/Medical the Due to (or es e consequence of): use as 1 Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 3 Probably 4 Unknown signed by 1 Yes 2 No STROKE Division of Vital Records, Completed by 8 page 2 should 24b. Were eutopsy findings available prior to completion of cause of daeth? 24e. Wes an eutopsy performed? peed hes 1 Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Attending Physician: director, 25. Was cese referred to medicel Be 26. Plece of Deeth (Check only one) Other: 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerai 28e. Deta of Injury (Month, Day Year) 27. Manper of Daath 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 1 Naturel 5 Panding Investigation death. 1 ☐ Yes 2 ☐ No spital or Attendi cours efter death neral Director: A 2 Accident 3 Suicide 6 Could not be datermined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homtolde Hospital 24 hours 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data end plece, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examinerinetion end/or investigation, in my opinion, daath occurred at the time, date end place, end due to the ceuse(s) and menner stated. Medical To the within 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 711 NAIDEN AUQUST 14, 2000 D26473 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dernard F Fozumian, NO 7/117 ADEN CHOIRE LANE

BALTO MD 71278

Registrar DHMH 16 Rev 6/95

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31. Dete filed (Month, Dey, Year)

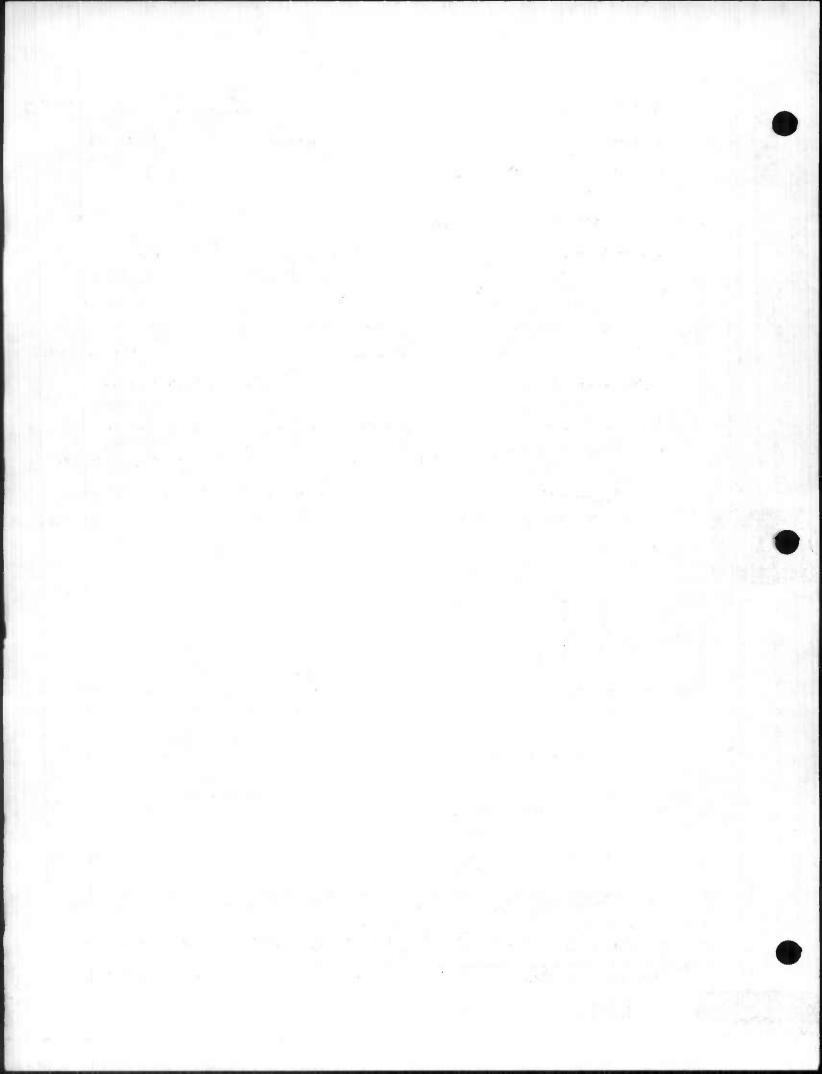
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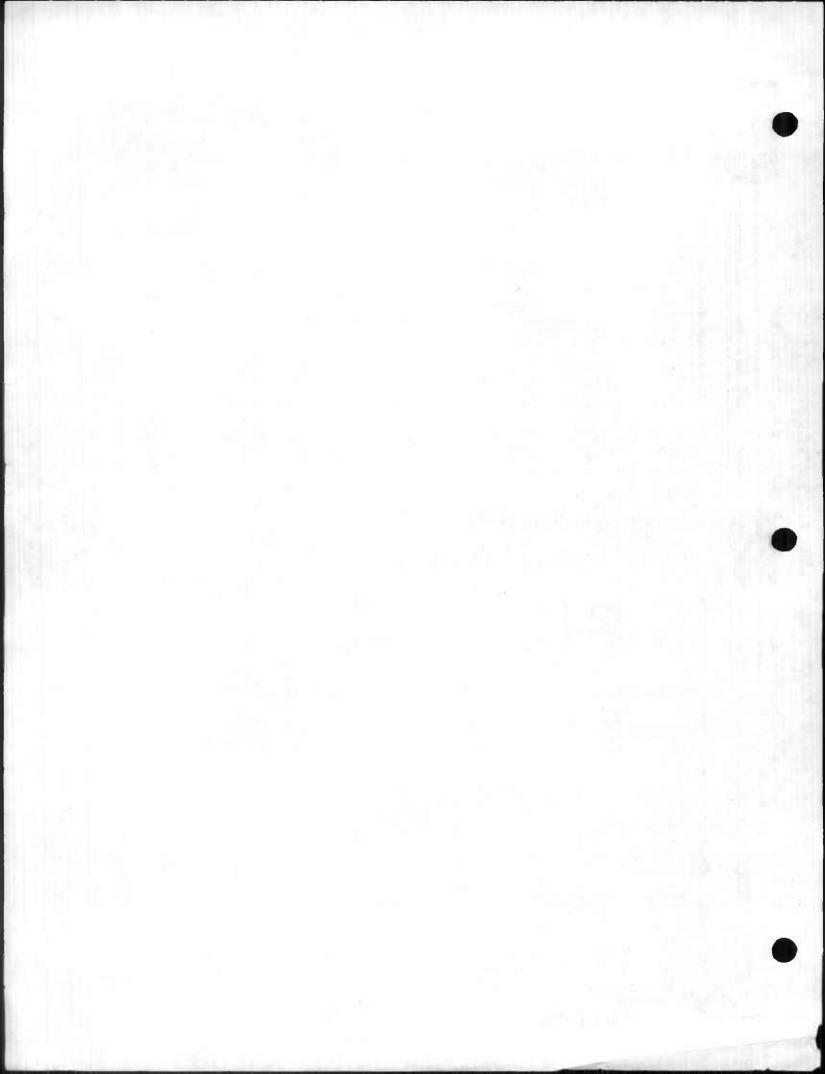
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State of Maryland / Department of Health and Mental Hygiene 26027 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John W. Wittmyer 08 13 2000 3:25p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07 06 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F Yrs. 217-14-5849 84 MD Director Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or thems 23e or 28e-f show 1 Yes 205No Director Baltimore Catonsville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21228 221 Osborne Avenue USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ∰Yas 2 □ No If Yes, Give Year or Datas: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Marriad 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: PV 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be 1 and Mental F is marked of 8 John Wittmyer Daniels 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Department of Health important: If Item 27 is 221 Osborne Avenue, Catonsville, Md 21228 Jean Wittmyer/ Wife Baltimore, 20b. Plece of Disposition (Name of cematery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete Pages 1 Burial 2 □ Cremation 3 □ Removel from State New Cathedral Cemetery 108 17 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarel Service Licensee 22. Nama and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 23a Part from the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate srianval Between Onset and Death **Physician** Immediate Cause (Finel disaase or condition resulting In death) /Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): 23b. Did tobecco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. P.0. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen 1□ Yes 2☑No 1 Yes 2 No Division of Vitai or Attending Physician: after deeth. Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) | HOS PIU 1□ Yes 2□ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide • Funeral Di 29a, Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 120 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alharme Har 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) haw st. 21201 128 DLC 32. Registrer's Signeture 31. Date filed (Month, Dey, Year)

Registrar

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2000



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Wright 3:00 PM Herbert August 15, 2000
4b. City, Town, or Location of Deeth 4c. County of Deeth /Medical 4e. Fecllity Neme (If not institution, give street end number) Examiner Bethesda Bethesda OF Mariner Montgomery Health If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours MM 20 F 225-05-0931 Yrs 88 Jan. 1, 1912 North Carolina Director Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at Bethesda 1 ☐ Yes 2 No Director Maryland MONTGOMERY Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20814 Hill Road # 1104 N 5225 OOKS death 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic avent, its waters. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: p Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Clerk U.S. GOVT SUPPLY 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Wright Bertha WatKINS Her bert WIFE 19b. Meiling Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 20814 19e. Informent's Neme/Reletionship (Type, Print) POOKS Hill Road Bethesda, Mary land
(Neme of Solder) 20c. Location - City or Town, Stete 5225 Beatrice Wright 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 8/21/00 20a. Method of Disposition 18 Buriel 2 Cremetion 3 Removel from State LINCOLN Memorial Cemetery Suitland, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Chinn Funeral Service 21 Signeture of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rd. ARL, Vq. 22206 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel CARDIAC ARRHYTHMIA disease or condition resulting in death) Examiner Due to (or es e consequence of) SEPSIC physician and the burial-transil Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the Due to (or as e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac þ 24b. Were eutopsy findings aveileble prior to Completed 24e. Wes en autopsy completion of cause of deeth? 1 ☐ Yes 25 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) exeminer's 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After 5 Pending investigation Hospital or Attending 24 hours after death. Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. 29a, Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) M.D', Ph.D. AUGUST 15, 2000 D 55054

REDLAND

AV. ROCKVILLE

State Registrar 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

KASID

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31. Dete filed (Month, Dey, Yeer) AUG 1 7 2000 17519

32. Registrer's Signeture

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SALLTE	est)	ATKINS			Month	Day	Year	3. Tima of Deeth 5:26p.m.		
An Contitue bloom of the national tension of	re street and number)	111111111		4b. City, Town, or L				J.20p.m.		
Prince George's H 5. Social Security Number 6. S 579 26 2156	ospital Sex 7. Age	(In yrs. last birthday	/) If Undar 1 Yaar Months Deys	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day,	Prince	e Geo	ace (State or Foreign try)		
		10c City Town or I	ocation				10	Od. Inside City Limits		
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	n	Year) 28b. Tima Injury			28d. Dascribe ho	w injury occur	red			
	28a. Place of Injur	y - At homa, farm, s (Specify)	traat, factory, office				ber or Rura	Route Number,		
29a. Certifier p Certifying Pt (Check only one) 2 Medical Example 1	niner: On tha basis of a	xaminetion and/or i	th occurred at tha ti nvestigation, in my	ma, date and place, opinion, death occur	end dua to the ce red at the time, de	eusa(s) and ma ete end plece,	annar es st end due to	atad. the cause(s)		
29b. Signature and titla of certifiar	C.A	Ori	29c. Lican	sa number		100				
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State of Maryland / Department of Health and Mental Hygiene 26030 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DAVID LEROY BRAWNER 2000 11:47PM August 4, /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ja Plata If Under 24 Hrs. Hours Min. Center Civista Medical Charles If Under 1 Year Date of Birth (Month, Day, Year) OCT. 3, 1957 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months WASHINGTON, D.C. 42 Yrs. 215-70-7759 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Directo WALDORF MARYLAND CHARLES or 288-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 20601 110784 OAK MANOR DRIVE Funeral Wes Decedent Ever in U.S. Armed Forces? 1 Yes 22 No If Yes, Give Yeer or Dates: 14. Race - American Indien, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1□ Yes 2□ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementery/Secondery (0-12) College (1-4or 5+) GUN MAKER GUN MANUFACTURER 11TH GRADE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY ESTELLE WARE BRAWNER Pages 1 and 2 should be nent of Health and Mental is marked FRANCIS LEROY BRAWNER 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau 110784 OAK MANOR DRIVE, WALDORF, MARYLAND 20601 MARY E. BRAWNER / MOTHER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 XBurial 2 □ Cremation 3 □ Removal Irom State JOSEPH'S CHURCH CEM. 8/9/00 POMFRET, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name end Address of Facility THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 ADIA C. Approximete Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) **Examiner** 40 H. Nontes Physician/Medical Examiner The law requires that the death certificate be axecuted burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Due te/(or as a consequ 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown weterbr Records, De d by Completed 24b. Were autopsy lindings available prior to 24a. Was an autopsy performed? phoods completion of cause of death? **page 2** certificate 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vitai Hospital or Attending Physician: funaral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 2 No 1 Nnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 1 Yes this 27. Manuer of Deeth 1 Natural 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, lerm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. completely (Check only one) 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner adjud. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7C Post Office Rd, Waldorf, Maryland 20602 Song C. Chon, M.D. 31. Dete liled (Month, Day, Year) AUG 0 8 2000

State Registrar

DHMH 16 Ray 6/95

32. Registra/s Signature

05032 00

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. amend item 6 per fh G787 9/8/00 yf State of Maryland / Department of Health and Mental Hygiene Amend# 23a.Part 1 & II. Per PHYS. PGC 8-4-2000 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 1:35 Pm MAYO RANKS JULY 2000 29 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MUSPITAL HOWARD HOWARD CONTY CEMPRAL COLUMBIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 180 M -200 Months Days Hours 223-96-098/ Usual Residence of Decedent Yrs. Director VIR9INIA 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 No Directo HOWAR Olumbia 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 633 238 2 044 LANC Funeral AR 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Bace - American Indian 11. Meritel Stetus Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 21215-0020 1 Yes 2 No Specify: Specify: BIACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) should be find Mental H BANK LOUISE and) 19b. Mailing Address (Street end Number or Ruret Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Pages 1 and 2 of of Health: HAZEL Washington. D.C. 20010 N.W. ARder Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/2/00 Washington, D.C. emetery 4 ☐ Donation 5 ☐ Other (Specify) any injury 22, Name and Address of Facility williams funcies service 21. Signature of Funeral Service Licenses The House lliams D.C. washington, 23a. Part1. Enter the disease, or complications that caused the cleath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS 36 HOURS Examiner Due to (or as a consequence of) 5 Days Physician/Medical Examiner ASPIRATION PNEUMONIA Aproorde O INDES The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) ASPIRATION DAY Due to (or as a consequenca of) Box P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 LNo 3 Probably 4 Unknown DISMORR Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? edicai Certification: To Be Completed M3PIRA TOURS 20 No 1 ☐ Yes 2 ☐ No of Vital Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 27. Manner of Deeth 28c. Injury at Work? Division or Attending 1 Naturel 5 Pending Investigation after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D completely filled Hospital 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dele and placa, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e, Certifier

To the 6

31. Date filed (Month, Dey, Year) State AUG 0 4 2000 Registrar

(Check only one)

29b. Signature and title of certifier

10724 UTTLE PATILYEUT DAVID O. NYAMJAM MO 22. Registrar's Signature.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0 36974

29d. Dete signed (Month, Dey, Year)

29, 2000 mg 21044

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State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	5654 Rock Quarr	y Terrace		10f. Zip Co	20747			USA		my r
Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U,S. 13.	Was Decedent	of Hispanic O	rigin? (Spe	ecify Yas or N	0- 14. Re	ce - Amaric	can Indian,
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	30. Name and address of person who	completed cause of death	(Item 23a) (Type							
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23a. Part I. Enter the disease, or complications from a dash. Do not enter the mode of dying, such as cerdiac or respiratory arrest, infance feath of specific plant failure. List only one dash on each line. Comparison of the control of the con	F 2 8	11/2 to 1	2	W.C.	Alexande	r S. Pope	Funera.	L Homes	3	07/7	
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Control of the cont		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaesa or injury that initiated evants resulting in death) Last	b. Du	ua to (or as a conseq	uance of):						
Control of the cont	for use		d						1		
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30. Nama and addrass of person who completed ceusa of death (Item 23s) (Type, Print)	Fune letely fi	(Check only 21) Medical Eas	the basis of e	kaminetion and/or inv	occurred et tha ti vastigation, in my	me, dete and plece opinion, death occu	red at the time,	cause(s) and mo deta and plece,	enner as atalec and due to tha	i. cause(s)	
30. Nama and address of person who completed ceusa of death (Item 23s) (Type, Print)	Toth	29b. Signature and titla of certification	Welt N	LS .				- 1	1	Year)	
State 31. Data filed (Month, Day, Year) 33/Registrar's Signature	4)	VENKAT. S. KAN	1ANAN 7501	SURRAT	1/	→ # 307	CLIN	TON A	1D 20	735	

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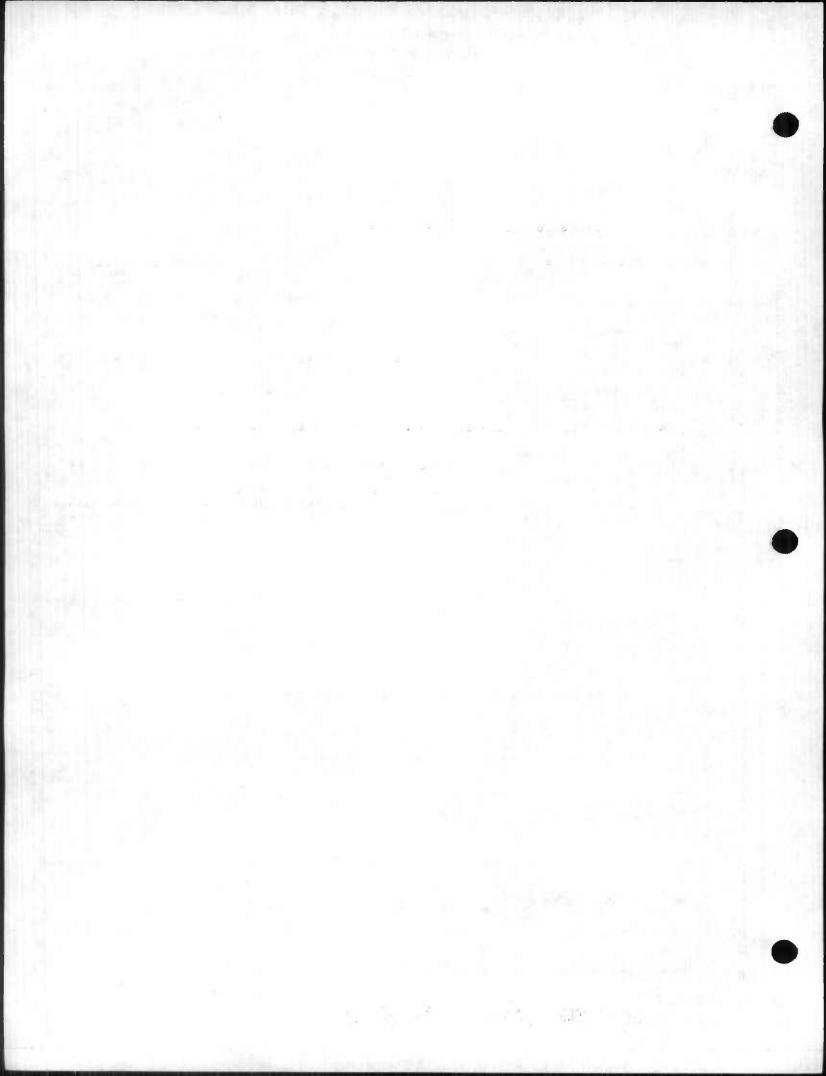
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State of Maryland / Department of Health and Mental Hygiene 10

									Certi	ificat	e of	Deal	th		Reg. No.		40	034
	1		1. Decedent's Nam	a (First, Midd	le, Las	t)								2. Deta of D	eath	MS.	3. Ti	me of Death
	Physicia		SIISTE M. BENEFIELD												05	:11 A.M		
	/Medic Examine		4a Facility Neme (/	lf not institutio	n, giva	street and nu	ımber)					4b. City,	Town, or l	Location of Dea	th 4c. Coun	ly of Death		
	•		MALCOLM	GROW N	4ED	ICAL CI	ENTER					CAME	SPRI	INCC	DDTM	TE OF	ODGE	1.0
	Funeral		5. Social Security N		6. Se		7. Aga (In yr	s. lest birt			1 Year	If Und	der 24 Hrs.	8 Date of B	rth	9. Birth	place (S	tate or Foreign
1	Director		709-10-4 Usuel Residence of		1[□M 2 🗓 F	90	,	Yrs.	Months	Deys	Hour	s Min.	Dec. 9,			any,	
	/land															10d. ins	ide City Limits	
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	within 72 hours after death with the Maryland ene. "ratural", or items 23e or 28e-f show than "natural Exeminer must be notified at	Funeral Director	8110 Ph		lac						207				United	l Sta	tes	
	or de	nu	11. Merital Stetus		Ш	Armed F		U,S.	13. Wa	as Dece es, spe	dant of H cify Cube	lispanic en, Mexi	Origin? (S)	pecify Yes or N o Rican, etc.)		ce - Amari eck, White		en,
000	ral', or h	þ	1 Never Merri 3 🖾 Widowed			1 ☐ Yes If Yes, G Year or (2 ⊈Mo iva Detes:		10	Yes	2₩ No	Spec	ity:		Specify: Black			
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IE 7	d with	E C	Elementary/Seco	ondary (0-12)		College ((1-4or 5+)	D	omes				~		Dri	vate		
	be filed tal Hygid of other event, p	Ö	17. Father's Name	(First, Middla,	Last)			D	Omes	CIC	Ling			ne (First, Middle	, Maiden Sume			
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	should and Men america umartic	10	19a. informent's No			voe. Print)		19b.	Mailino	Address	s (Street	and Nur			ber, City or Town	n. State. Zi	ip Code)	
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NAME Baltin	Depart Import any Inje		21. Signature of Eu	neral Service	Licen	1	A 711	_	S	tewa	art 1	Fune	ral H	lome, I	nc. ,Washir	oton	D	C 20010
00	100	1	23 Part1. Enter ti	he disease, or	r comp	dicetions that	caused the de	eth. Don								gcon	Appro	ximate
UP	Physician		hock, or hea	n tellure. List	Only C	Me cause on	each line.											al Between t end Death
	/Medical		Immediete Cause ((Finat		DYSE	RYTHMIA									1	20	MTN
	Examiner		disease or condition resulting in deeth) Dysrythmia Due to (or es e consequenca of):														MITIN	
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	certificate be executed ding physician and use as the buriel-transit	Examiner																
ó	an ar	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.															
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99	E 0.6	Neg W																
Вох	leath certific attending p		d.															
	deat of fo	sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributes											to the c	ouss of death?			
0.	es that the death cer igned by the attendin be detached for use	Physician	DIABETIS MELLITUS											1	1 Yes 2 No 3 Probat			4 Unknow
Ś	an sthe	by	DIABET	15 MEL	الليا	.08				_	_							****
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	ral Delli	ပိ		V														
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai Certification:	29e. Certifier (Check only one)	12 Certifyir 2 Medicai	eg Phy Exami	iner: On the b	e best of my kr pasis of examination oner steted.	nowledge nation and	deeth o	stigation	et the tir , in my o	me, date pinion, o	end pleca death occu	red at the time	cause(s) end r , date and place	anner as	stated. to the ca	tuse(s)
	within 2 the comple	×	29b. Signature and	title of certifie	r	20				29	c. Licens	e numb	er		29d. Dete sign	ed (Month	, Day, Y	'ear)
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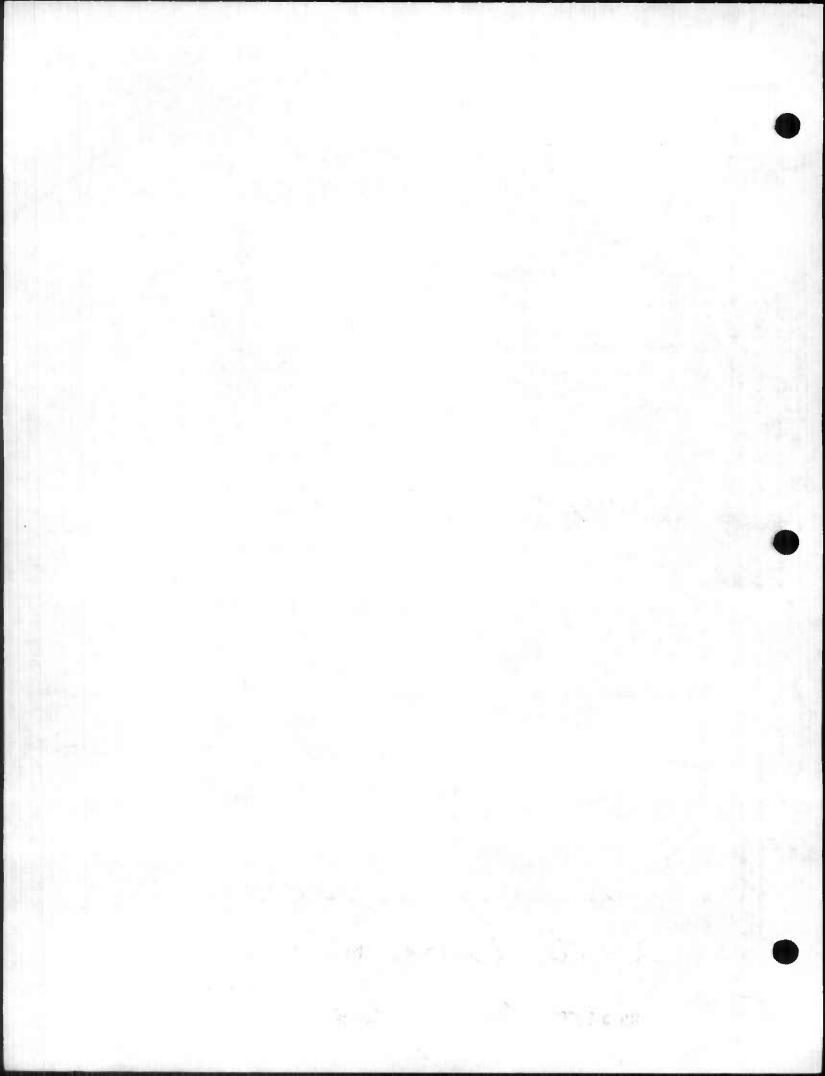
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State of Maryland / Department of Health and Mental Hygiene 00

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			Cer	tificate of l	Death	Re	g. No.		Till roll					
Physician /Medical	1. Decedent's Nama (First, Middla, La Justelma Ma	s) rtin Brigo	gs.			2. Data of Death			of Death pm					
Examiner	4a Facility Nama (If not institution, giv 1524 Jutewood Ave		ID 207		b. City, Town, or L Landove			of Death e George's						
Funeral Director	5. Social Security Number 6. S 220-26-8867	ax 7. Aga (In yrs. 68	last birthday) Yrs.	If Under 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, 9/18/31	Year)	9. Birthplace (Stata Country) Eden, MD	or Foraign					
yland	Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10c													
or 2844 sign of 28	MD Prince G	eorge's I	andove	r				17E Yas	s 2 No					
or 28	10e. Street and Number			10f. Zip Coda		10	10g. Citizen of What Country?							
23a 23a ust b	1524 Jutewood Av	enue		207	785		U.S.							
which is four arise open with the maryland than "natural", or items 23e or 28e-1 show he waddell Examiner must be notified at the mark by marked by Funeral Director.	11. Marital Status 1 □ Nevar Marriad 2 □ Married 3 ☎ Widowed 4 □ Divorced	12. Was Decedant Evar in U Armed Forcas? 1 ☐ Yas 2 Å No If Yas, Giva Yaar or Datas:	11	Vas Decedant of H f Yas, specify Cuba I□ Yas 2XXNo	lispenic Origin? (Sp an, Maxican, Puarto Specify:	ecify Yas or No- Ricen, atc.)		ce - Amarican Indian, ick, Whita, atc. fy: Black						
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2 2	19a. Informant's Neme/Ralationship (Cynthia Briggs/Da	ughter	ral Routa Number, Pl., Cli											
ortent: if hem 27 injury or other ti 8-	Cynthia Briggs/Daughter 20a. Method of Disposition 1													
Important: If he any injury or of once.	21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., DC 20019 23a. Part1. Enfar tha disaase or complications that causad tha death. Do not antar tha mode of dying, such as cerdiac or raspiratory arrast, Approximata													
ing physician and as the burial-transit and Medical Examiner	disease or condition rasulting in death) Sequentially list conditions, if any, leeding to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last	Dua to (or as a consequence of): b. Dua to (or as a consequence of): any, laeding to immediate susa. Enter Underlying ause (Disease or Injury ause (Disease or Injury c. Due to (or as a consequence of):												
d by the attending etached for use a:	Part II. Other significant conditions of	ontributing to death but not ras	ren in Part I.	23b. Did tobacco was contribute to the causs of deat										
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page 2						1 🗆 Ye	s 25 No	1 Yas 20	□ No					
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led in by	4 Homicida datermined	Zoa. Flace of Injuly - At II	28a. Place of Injury - At homa, farm, street, lactory, office building, atc. (Specify)					ber or Rural Routa Nu	muer,					
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To the common	29b. Signatura and title of certifiar 30. Nama and address of person who	y and	pon	29c. Licans	255°		od. Data signe	d (Month, Day, Year)						
10)	I. Stanley And	erson,M.D. 116	0 Varnu		E.#216,W	ash.,D.C.	2001	7						
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	Certificate of Death	Reg. No.	20000
)		2. Dete of Deeth	3. Time of Deet

Physician /Medical Examiner **Funeral** Director

the Maryland 28a-f show must be notified at ŏ "natural", or items 23a death traumatic event, the Medical Examiner 72 hours after permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental thygiene. Important: If Item 27 is marked other than "rany injury or other traumetic event, trailing any injury or other traumetic event, trailing any once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the burial-transit signed by t page 2 should has certificate funeral director, this After the

P.O. Box 68760,

Records,

Division of Vital

The law requires that the death certificate be executed Hospital or Attending Physician: s after death. in by To the Hospital within 24 hours a To the Funeral C pelli completely

1. Decedent's Neme (First, Middle, Last JULY 27, Day 2000 Yeer MILDRED BECKER BUSHMAN 2:25PM 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day Ye DEC. 31, 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign Year 1914WASHINGTON, D.C. Months Deys Hours Min. 1□M 2₩F 577-10-4270 85 Vre Usual Residence of Dacedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits **FAIRFAX** VIRGINIA ANNANDALE 1 Yas 2 No Director 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? 22003 5109 BLUERIDGE AVENUE U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Merried WHITE 1 ☐ Yes 2 No Specify: p 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usuei Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meidan Sumeme) Be JULIUS T. BECKER GERTRUDE CHISUM 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) SALLIE MILLER - DAUGHTER 5109 BLUERIDGE AVE ANNANDALE, VA 22003 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete Buriel 2 Crametion 3 Removal from State 4 □ Donetion 5 □ Other (Specify) NATIONAL MEMORIAL PARK 8-1-00 FALLS CHURCH, VA 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility DEMAINE FUNERAL HOME 5308 BACKLICK ROAD SPRINGFIELD, VA 22151 X 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errast, shock, or heart feilure. List only one cause on each line. Approximete Intervei Between Onset end Deeth ascular accordent Immediate Ceuse (Fine) disease or condition resulting in deeth) Due to (or es e consequence of): Examiner morrer Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disease or injury that initiated evants resulting in death) Lest Due to (or es e consequenca of): OSIS Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p Completed 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2010 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturei 1 Tyes 2 No 2 Accident 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, fectory, offica building, atc. (Specify) 4 Homicide 1 Certifying Physician: To tha best of my knowledga, daath occurred et the time, deta end piace, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred et tha tima, date and piece, end due to tha cause(s) end menner steted. 29e. Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

31. Dete filed (Month, Dey, Year) JUL 3 1 2000



Kares

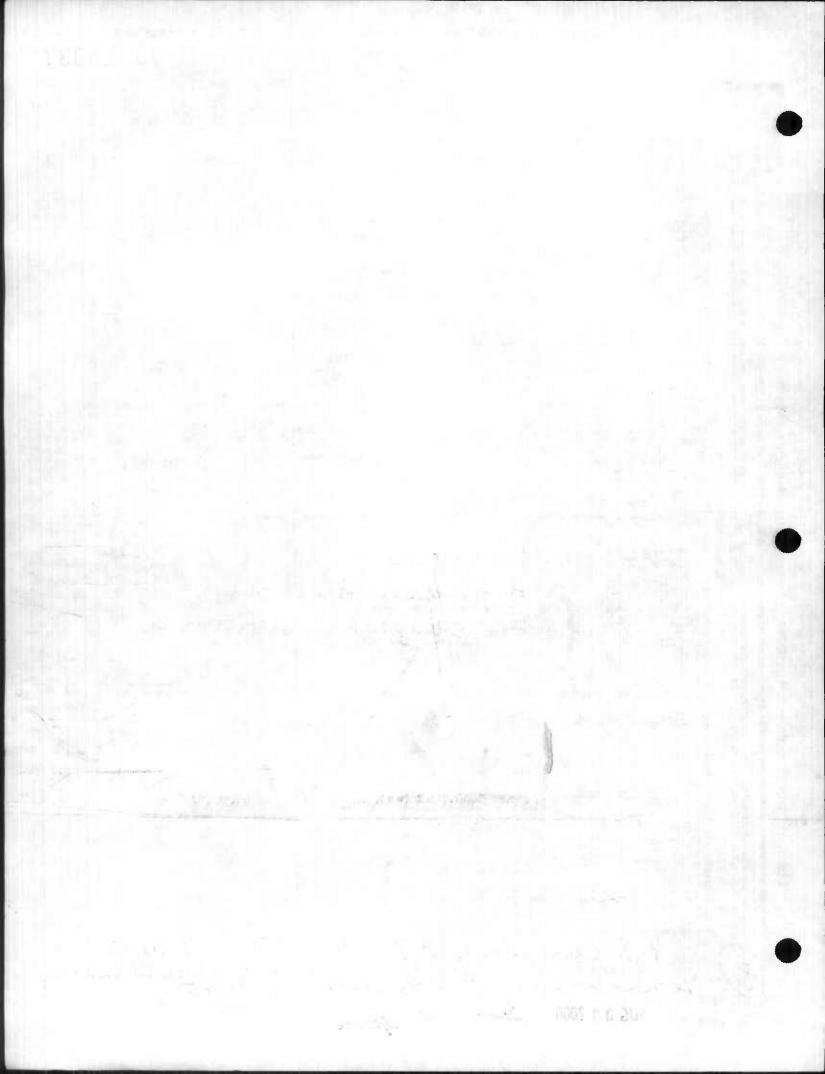
30. Neme and address of person who complated cause of death (itam 23a) (Type, Print)

ROCKVILLE, MD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene O O

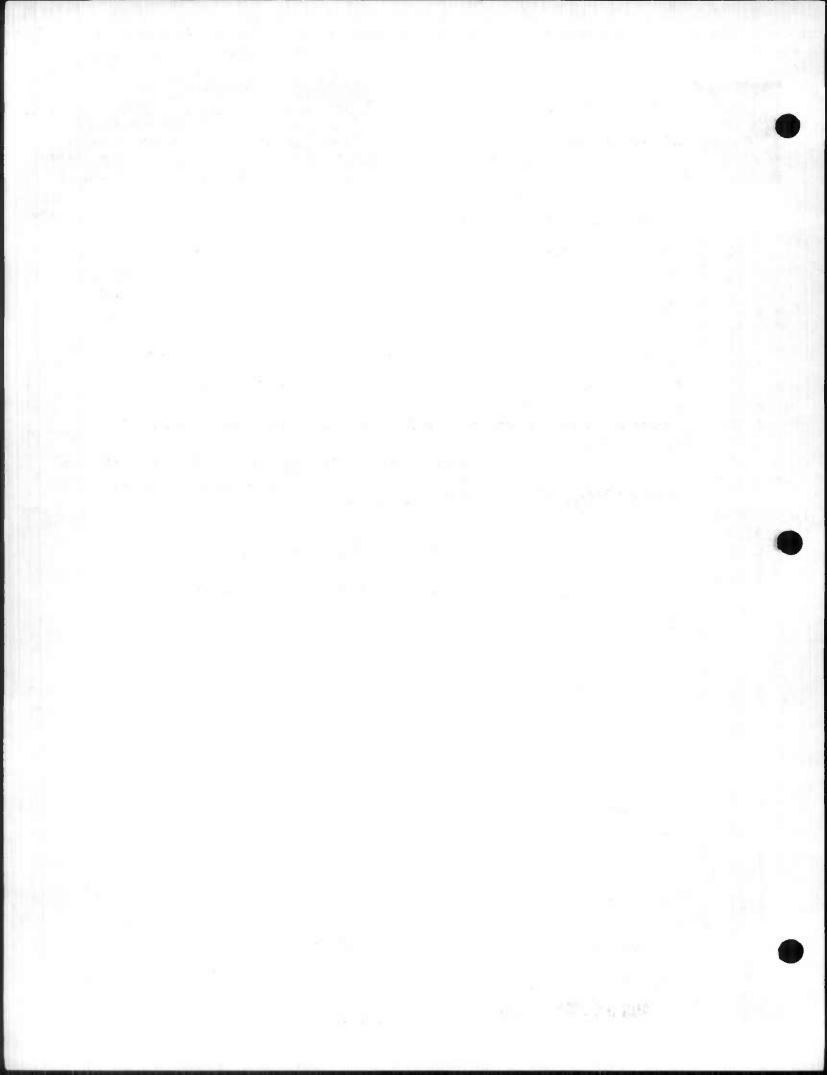
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	0 1	MONROE	REX					1.5	MILDRED PINKNEY						
a ma	19a.														
Par I	DENISE A BELL (daughter) 1227 NALLEY ROAD, LANDOVER MARYL											ARYLAND 20c. Location -			
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth **Physician** Month Day ALICE VIRGINIA BROWN 2000 1:00 p.m. August /Medical 4e. Fecility Name (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner REGENCY NURSING HOME FORESTVILLE PRINCE GEORGE'S If Under 1 Yeer If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpisce (Stata or Foreign Country) **Funeral** 1□M 2以F Yrs. Director 88 577 38 3103 June 4,1912 Bethesda, MD Usual Residence of Decedent the Marylend Pages 1 and 2 should be filed within 72 hours after death with the Marylen neat of Health and Mertal Hydiene. Internet of Health and Mertal Hydiene. Intit if them 27 is marked other than "natural", or thems 23a or 28a-f show ury or other traumatic event, the Merical Examine must be notified as 10b Counts 10c. City. Town or Location 10d. Insida City Limits 1 Yes 2 No Director Maryland Prince George's Seat Pleasant 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6233 Addison Road 20743 USA Funeral 12. Wes Decedent Evar In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yas 2 ☐ No If Yes, Give X Yeer or Dates: Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 K No Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th Domestic Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Harvey Simms Isabelle Bundy 19a. Informent's Name/Reletionship (Type, Print) 19b. Meliing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Thelma Washington/daughter 6233 Addison Road Seat Pleasant, MD 20743 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 18 Burial 2 ☐ Cremetion 3 ☐ Removei from State permit. Page Depertment of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Othar (Specify) Washington National Cem 8-7 Suitland, Maryland 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD Funerel Sarvice Licensae 4308 Suitland Road Suitland, MD 23e. Pent. Enter the disee of complications that ceused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Betw Onsat and Deeth **Physician** Ischenic Cardio myopathy /Medical Immediate Ceuse (Finel disaase or conditio resulting in deeth) Examiner Due to (or as e consequence of): Physician/Medical Examiner Coronary The law requires that the deeth certificate be executed physicien and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Due to (or as a consequence of): P.O. | Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by 1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. by 24b. Were eutopsy findings available prior to completion of ceuse of death? Completed 24e. Wes an autopsy parformed? page 2 certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was cese referred to medice! exeminer? Be 28. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 LN6 this 27. Manner of Deeth 1 [Natural Certification: 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No 2 Accident s after deeth 6 Could not be determined 3 ☐ SuicIde 28e. Piace of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 Sertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. Medicai completely (Check only 29b. Signature end title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 039550 30. Neme and eddress of person who comple Hayar, Jr. m. P. 4850 Forbes Blud. Lanham, Ma. 2070 6 George C 31. Date filed (Month, Day, Year)
AUG 0 3 2000 32. Registrer's Signeture State Registrar

DHMH 16 Bay 6/95



State of Maryland / Department of Health and Mental Hygiene 00 26039

J96-18-2733 Joual Residence of Decedent Oa. State 10b. County Maryland Prince Go Oe. Street and Number 1004 Quietview 1. Marital Status 1 Never Married 3 3 Widowed 4 Divorced 15. Decedent's Ec	LLOFATTO e street and number) Drive lex 7. Age (I 87 LOTIVE 10. Was Decedent Eve Armed Forces? 1 1 2 8 2 No If Yes, Give Year or Detes: Jucation and completed) Collega (1-4or 5+) Type, Print) i/son	Capito. or in U.S.	Months n or Location 1 Heigh 10. Z 13. Was Deciding the Yes, sp 1 Yes Decedent's Us (Give kind of wife. DO NOT)	ts Deys ts Deys to	Bapitol Hunder 24 Hr Hours Mi Hours Mi Bispenic Origin? Ben, Mexican, Pue Specify: Beation during most of well	S. Date of Bi (Month, b) April	Day 29 20 th 4c. County of Prince rth ay, Year) 28, 1913	of Deeth George's 9. Birthplace (State or F. Country) New York 10d. Inside City Yes 2 That Country? 1- American Indian, k, White, etc. White			
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1004 Quietview Social Security Number Social Security Number Social Security Number 6. S 966-18-2733 Sual Residence of Decedent Oa. State 100. County Maryland Prince Go Ob. Street and Number 1004 Quietview 1. Marital Status 1 Never Married (Specify only highest grave) Elementary/Secondary (0-12) 6th 7. Fether's Name (First, Middle, Last) Villiam Puchalski 19a. Informant's Neme/Relationship (Edward Koziresk: 10a. Method of Disposition 1 Burial 2 Cremation 3 A	Drive A corge S S S	Capito. or in U.S. 16e. Ba	Months n or Location 1 Heigh 10. Z 13. Was Deciding the Yes, sp 1 Yes Decedent's Us (Give kind of wife. DO NOT)	ts Deys ts Deys to	Bapitol Hunder 24 Hr Hours Mi Hours Mi Bispenic Origin? Ben, Mexican, Pue Specify: Beation during most of well	Heights 8. Dete of Bi (Month, Di April	Prince Pr	of Deeth George's 9. Birthplace (State or F. Country) New York 10d. Inside City Yes 2 That Country? 1. American Indian, k, White, etc. White			
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7. Fether's Name (First, Middle, Last) Villiam Puchalski 19a. Informant's Neme/Relationship (Edward Koziresk: 10a. Method of Disposition 1 Burial 20 Cremation 3 4 Donation 5 Other (Specification)	Type, Print) i/son		rtender	/Wait	Bartender/Waitress						
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19a. Informant's Neme/Relationship (Edward Koziresk: 10a. Method of Disposition 1 Burial 20 Cremation 3 C 4 Donation 5 Other (Specific	i/son	19b			18. Mother's N	Name (First, Middle, Maiden Sumame) Eva Baranski					
Edward Koziresk	i/son						nski				
0a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)								State, Zip Code)			
1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		10	04 Quie	tvie	w Drive	Capitol Heights, MD 2074					
4 ☐ Donation 5 ☐ Other (Specify		20b. Placa of	Disposition (No	ame of		Data		City or Town, State			
21. Signatuje of Funeral Service Licer	y) I		olitan	Crema	atory			ia, Virgini			
Jugward	board and	m	22. Name 8	and Addre	ss of Facility MA	RSHALL'S	FUNERAL	HOME OF MD			
23a Part1 Enter the disease or com	ac or respiratory	Suitland, Maryland 20/85									
Sequentially list conditions, ff any, leeding to immediate cause. Entar Underlying Cause (Disease or Injury hat initiated events resulting in death) Last	C	e to (or es a	consequence of):							
	d	Coro	0	-							
Pert II. Other eignificant conditions o	ontributing to death but n	ot resulting in	the underlying	cause giv	ven in Pert I.	23b. Dic	i tobacco use con	ntributa to the cause of			
						1	Yes 2□No	3 Probably 4 ☑ U			
								24b. Were autopsy fin available prior to completion of cau of daath?			
						10	Yes 200 No	1 ☐ Yes 2 ☐ N			
25. Was casa referred to medical					26 Place of C	eath /Check only	ona)	_			
axaminer?	Hospital:	2∏E9/0	tration 3 1	Ott Ott	nor:			er (Specify)			
7. Manner of Death 1 Natural 5 Pending	28e Date of Injury (Month, Day Year) 28b. Time of Injury Work?										
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, offica building, atc. (Specify)							(Street and Number own, State)	er or Rural Route Numbe			
	niner: On the basis of ex	aminetion en									
29b. Signature and title of certifier			2	9c. Licens	se number		29d. Date signed	d (Month, Day, Year)			
1/ A	. /			70.0	E(10		A	2000			
) C. Sanac no. D25640							August 1	, 2000			
	A VA CH	-		01.42	0 mm A	C F	Uachi	on DC 2003			
of the control of the	mmediate Cause (Final issease or condition asulting in daeth) Sequentially list conditions, fany, leeding to immediate cause. Enter Underlying Lause (Disease or Injury hat initiated events esulting in death) Last Pert II. Other eignificant conditions of the cond	mmediate Cause (Final issease or condition asulting in deeth) Sequentially list conditions, I any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury neat initiated events esulting in death) Last Output Dustrial: Dustri	Due to (or as experience) Sequentially list conditions, assure for the least of modified assure. Enter Underlying Cause (Diseasa or Injury nat initiated events esulting in death) Last Set II. Other eignificant conditions contributing to death but not resulting in death) Last Set II. Other eignificant conditions contributing to death but not resulting in death last axaminer? I a year last a year	mediate Cause (Final disease or condition asulting in daeth) Due to (or as e consequence of END 3 to Due to (or as a consequence of END 3 to Due to (or as a consequence of END 3 to Due to (or as a consequence of END 3 to Due to (or as a consequence of Consequence of END 3 to Due to (or as a consequence of END 3 to Due to (or as a consequence of Con	mediate Cause (Final disease or condition asulting in daeth) Due to (or as e consequence of): END STAL Due to (or as a consequence of): END STAL Due to (or as a consequence of): END STAL Due to (or as a consequence of): Coronay ending Du	mediate Cause (Final disease or condition asulting in deeth) Due to (or as e consequence of): END STATE Due to (or es a consequence of): END STATE Due to (or es a consequence of): END STATE Due to (or es a consequence of): Consequentially list conditions, lany, leeding to immediate aguse. Entart Underlying ause. Chiral Underlying auses. Chiral Underlying ause of light of the seculing in death) Last Due to (or es a consequence of): Consequence of	mediate Cause (Final Jisease or condition as Uffernia — Due to (or as e consequence of): END STAJ 100 — Due to (or as a consequence of): END STAJ 100 — Due to (or as a consequence of): END STAJ 100 — Due to (or as a consequence of): END STAJ 100 — Due to (or as a consequence of): Coronag and 100 — Due to (or as a consequenc	Due to (or as a consequence of): END STATE Due to (or as a conse			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Jaly **Physician** Bartock Ann Κ. 2119 2000 25 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner George's Cheverly Hospital H Under 24 Hrs. 8 Dete of Birth Month, Day, Dec. 3 If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Y921 Months 1□ M 20 F 78 235-24-3722 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c City, Town or Location 10d. Inside City Limita 28a-f show the Medical Examiner must be notified at Prince George' Landover Hills Director 1♣ Yes 2 No 10e. Street and Number 4709 Cooper Lane 10g. Citizen of What Country? 10f. Zip Code 20784 8 Nerns 23a Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after of Department of Heelith and Mentel Hygiene. Important: If item 27 is marked other than "natural", or han any injury or other traumatic svent, the Medical Emerican page. Black, White, etc. Specify: White 1 Never Married 2 Namied Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) National Science Foundation Program Assistant 18. Mother's Neme (First, Middle, Maiden Sumame)
Mary Strapec 17. Father's Name (First, Middle, Last) Be Joseph Kucbell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4709 Cooper Lane, Landover Hills, Md 20784 19a. Informent's Name/Relationship (Type, Print) Paul F.Bartock, Sr./Husband 20b. Piece of Disposition (Name of commetery, crematory or other place)
Cheltenham Md. Veteran's 8/2/00 Cheltenham, Md. 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rendon-Hale Funeral Home
9013 Annapolis Road, Lanham, Md20706 Uneral Service Licenses that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, find cause on each line. Approximate Intervel Betw disease, or compli allure. List only or Onset and Death **Physician** Uterine Concinona with Metas tasis /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of). attending p 88 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 certificate 1 Ves 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 8 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1- Natural 5 Pending 1 Yes 2 No investigation 2 Accident

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun

Registrar

DHMH 16 Rav 6/95

31. Date filed (Month, Day, Year)

JUL 3 1 2000

3 Suicide

29e. Certifier (Check only one)

4 Homicide

29b. Signeture end title of certifier

6 Could not be determined

m 300/ 32. Registrar's Signature

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

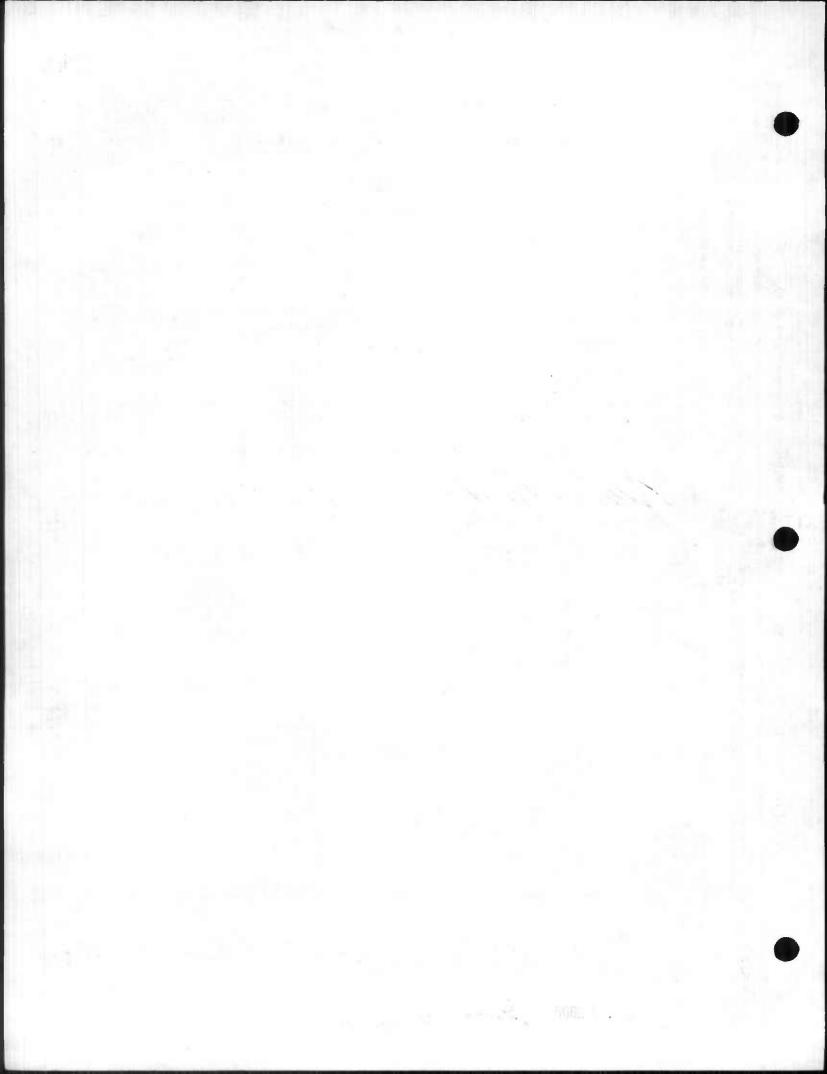
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

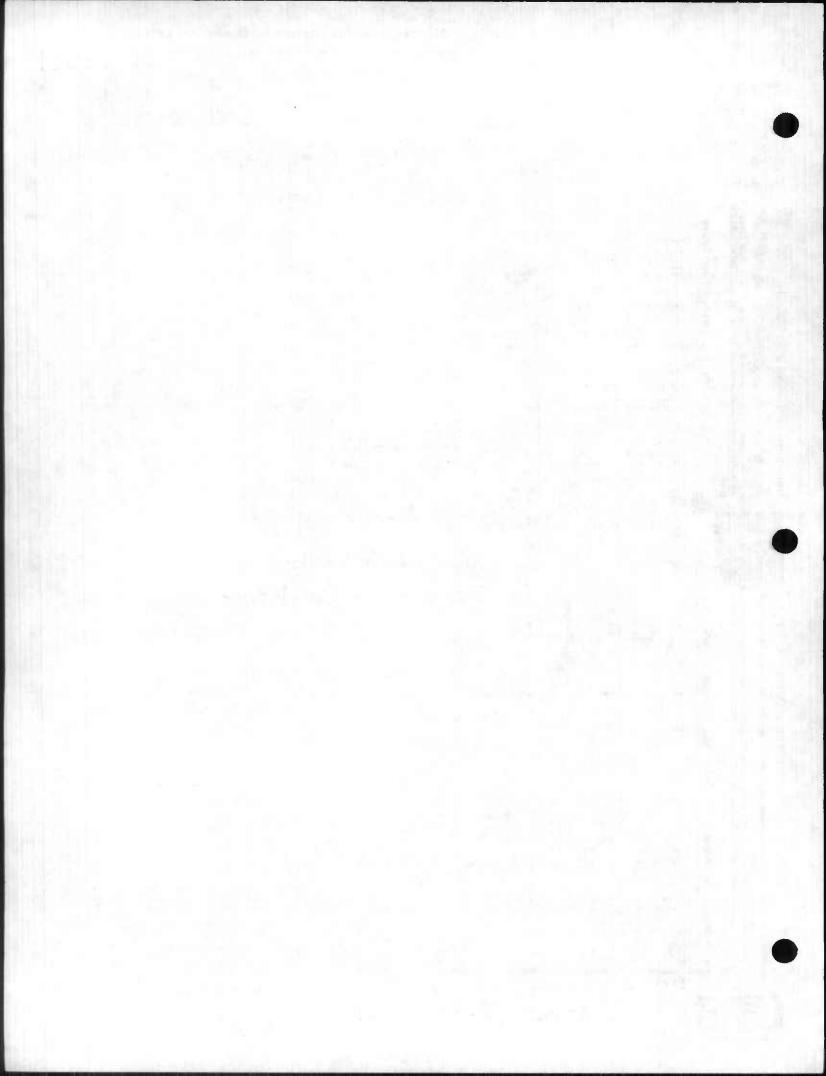
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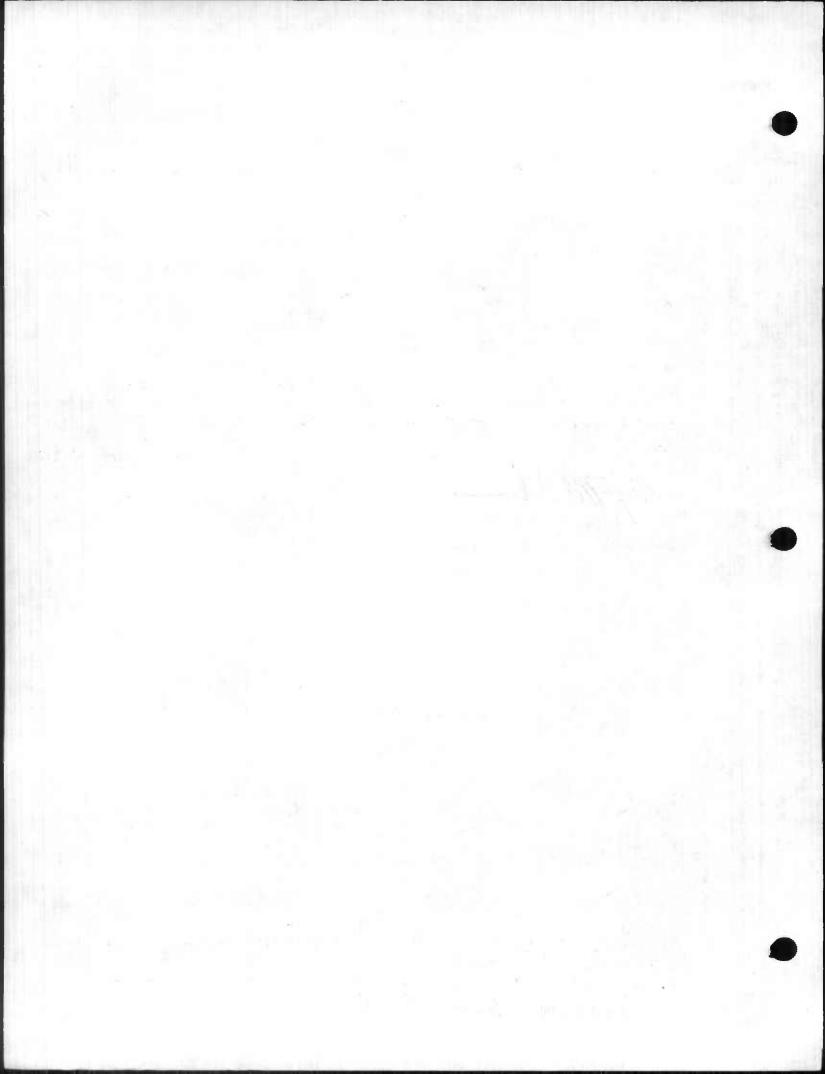
				Certific	cate of	Death		Reg. No.	0 21	0041
	1. Decedent's Nama (First, Mid	dla, Last)					2. Data of De Month	ath Day	Veer	Time of Death
Physician /Medical	LYNNE	M			BU	WEN	AUGUST		2000	12:29
Examiner	4a Facility Name (If pot instituti	on, give street and num	ber) /	101		4b. City, Town, or		4c. County	of Death	
	TILE Tobas	Harlin	c Hos	sitaL		Baltim	mec; 4	Balti	more	
neral	5. Social Security Number	6. Sex 7	. Age (In yrs/ Jas		ndar 1 Year	If Under 24 Hrs				(State or Foreign
tor	228-62-2153	1 M 2 F	54	Yrs. Mor	ths Days	Hours OCT	8. Date of Big (Month, Da ober 15	1945	Virgi	nia
	Usual Residence of Decedent									
	10a. Stata 10b. Coun		10c. City, 1	Town or Location						nside City Limits
ş	Maryland Wash	nington		Hagerst	OWII				1	Yas 210 No
9	10e. Street and Number			10	. Zip Code			10g. Citizen of V	What Country?	
ral Director	18807 Fountain	1 Terrace			21742	2		USA		
Funeral Director	11. Marital Status	12. Was Deced	dent Ever in U,S.	13. Was D	ecedent of H	lispanic Origin? (S an, Maxican, Puer	Specify Yes or No	- 14. Rac	a - Amarican Ir	ndian,
3	1 Nevar Merried 2 Me	erried 1 Tas 2	2X No				to rican, etc.)		ck, White, etc.	
by	3 ☐ Widowed 4 ☐ Divorce	od Year or Dai	tes:	10 48	as 2K No	Specify:		Specify	: WIII.LE	
Completed		ent's Education		16a Decedent's	Usual Occup	ation	adata a	16b. Kind of Bu	usiness/Industr	у
Pie	Elementery/Secondary (0-12)	est grade completed) College (1-	40(54)	life. DO NO	or work dona OT use retired	during most of wo d)	rking			
E	Lionontoly/oddondoly (o 12)	2	401 017	program	n mana	ger		C. T.	A., Inc	
Bec	17. Fathar's Nama (First, Middle	i, Last)				18. Mother's Na	me (First, Middle	Maiden Suman	10)	
ToB	James Anthony	Albano, Sr.				Mildred	Josephi	ne Alb:	is	
_	19a. tnforment's Neme/Relation	nship (Type, Print)		19b. Meiling Add	dress (Street	and Number or R	urel Route Numb	er, City or Town,	State, Zip Cod	(e)
	Andrew J. Bowe	n. TV	2.00	18807 F	ountai	n Terrac	e Hager	stown.	Marvlar	d 21742
	20e. Method of Disposition		20b. Pled	e of Disposition	(Name of		Date	20c. Location -		
To Be Comp	1 Buriai 2 Cremation		iate	etery, cremetory			10100	Doolel ond	177	inic
	4 Donation 5 Other (ROCK	land Cem	e Lery ng and Addre		3/8/00	Rockland	i, virg.	ша
SUCE	21 Signature of Fundal Service	much		Gera	ld N.	Minnich	305 N	. Potoma	c Stree	et
_	Sucrey 11	18/1/10		Fune	ral Ho	ome	Hager	stown, M	laryland	d 21740
	23a. Part1. Enter tha disease, shock, or heart failure. Li	or complications that ca st only one cause on ea	used tha deeth. ich line.	Do not enter the	moda of dyir	ng, such as cardia	c or respiratory a	rrest,	tnta	oroximate irval Between
n									On	set and Death
at	Immediate Cause (Final disaese or condition		ARTEI	ZiAL-	THR	DMB05	15		2	MONTHS
r	resulting in death)	d	Due to (or a	s a consequance	of):			11.00		
Examiner			TNTRA	CRANII	XI. H	EMORRE	YAGE		3	DAYS
E	Sequentially list conditions,	D		s a consequence		, O - C				
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	FI STANDARD								
edicai	that initiated events resulting in death) Last	С.	Dua to (or as	s a consequanca	of):					
Medical Examir	1650king in Godin Last									
leted by Physician/I		d							1	
io io	Part II. Other significant condit	lons contributing to der	ath but not resulting	ng in tha underly	ing cause giv	ven in Part I.	23b. Did	tobacco uss co	ntribute to the	cause of death!
t X							18	yea 2□No	3 Probabl	y 4 Unknow
>								1		
Completed by Physician/I	E STATE OF STATE						24a. Was	an autopsy	24b. Were a	utopsy findings
i i							репо	ormed?	comple of deat	ele prior to
E										14
							10	Yes 2 No	1 🗆 Ye	s 200No
8	25. Was case referred to medic examiner?	Magnitals of			000		ath (Check only	one)		
2	1 ☐ Yes 2 📉 No				DOA Oth	4 LI Nursing I	Home 5 Resi			
O.	27. Manner of Death	ing 28a. Date of	(Injury , Day Year)	Bb. Time of Injury	28c. Injur		28d. Describe	how injury occur	red	
Cat	2 Accident inves	tigetion		М	10	Yes 2 □ No				
=	3 Suicida 6 Coul 4 Homicide deter	mined 289. Place	of Injury - At home g, etc. (Specify)	e, farm, street, fa	ictory, office		28f. Location (City or To	Street and Numb wn, Stete)	per or Rural Ro	ute Number,
Certification:										
edicai	29a. Certifier 15 Certify	ing Physician: To the b	est of my knowle	dge, deeth occu	rred at tha tir	me, date and place	e, end due to the	cause(s) and ma	anner as stated	d.
B	one)	and menne	er stated	i and/or mvestige	ation, in my c	pinion, death occ	urred at the time,	dete and piece,	and due to the	cause(s)
2	29b. Signature and title of certif	er			29c. Licens			29d. Data signe		
	Thui 1	Vanger	MO		Q-	7328	N. Sale	AUGUST	04,	2000
	30. Nama and address of perso		of death (Item 2)	3a) (Type, Print)						
	THAI NGUYER				ET	BALTIN	NORE ,	MD 21	287-	-9106
State	31. Date filed (Month, Day, Yea		girtrar's Signatur		1	1	100			
State	/\116 A	7 2000	122	19	1000	Kai'				



State of Maryland / Department of Health and Mental Hygiene 26042. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** BOMBERGER Blanche Irene August 8:00 AM 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** WASHINGTON Reeders Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 28 F Dec. 17, 1909 Director 90 Maryland 216-80-2971 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Washington Hagerstown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò 11226 Hollywood Rd. 21740 USA 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 K No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Blanche 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Housewife Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Roy William Gower Anna Mae Hemphill 20 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) or other tr. Hagerstown, MD 21740 Lindin I. Easterday (Daughter) 17249 Lappans Rd. altimore, Me 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Pages 8 1 Buriel 2 Cremetion 3 Removel from Stete Greenlawn Memorial Park August 7,2000 Williamsport, MD 21795 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be assected the bunal-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Box 68760. Physician/Medical 980 s certificate has been signed by the a director, page 2 should be detached f Pert II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? P.O. 2 No 1 Yea 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Wes case referred to medical 26. Placa of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Menner of Death 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Division Naturel 5 Pending Investigation death. 1 Yes 2 No **2** ☐ Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Placa of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide pelily filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) å 29b. Signeture and title ot certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2 2000 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713/ 301-432-8470 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture State AUG 0 7 2000 Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 00 26043

			Certifica	ate of Death	R	eg. No.	20043
Physician /Medical	1. Decedent's Nama (First, Middle, Li	2 M. BO	llinge	^	2. Date of Dear Month	Day the Ye	3. Time of Death
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Funeral Director	207-30-5243	Sex 7. Age (In yrs	Month	der 1 Year If Under 24 H hs Days Hours M		2,1917 9.	Birthplaca (Stete or Fore Country) PA
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or and		imore I	Freeland				1 ☐ Yes 2 🔀
or 28a-f show be notified at Director	10e. Street and Number	2.11.02.0		Zip Code	1	0g. Citizen of Wha	f Country?
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at, or han Examinar by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		cedant of Hispanic Origin? pecify Cuban, Mexican, Pu 2 No Specify:	erto Rican, etc.)	Black, V	White, etc.
Scal Scal	15. Decedent's E	ducation	16a. Decedent's U	sual Occupation work done during most of v T use retired)	working	16b. Kind of Busine	ess/industry
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nent of He unt. If Nen ary or offi	20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Spec	_Hemovai from State	Place of Disposition (camatery, crametory) Mt. Zion	Name of prother place) Cemetery	Aug. 14,	20c. Location - City Freela:	
Departs imports any inja ance	21. Signature of Funeral Service US	Joses Joses		and Address of Facility Jecond Stree			
hysician /Medical xaminer	23a. Part. Liver the disease, or cornection of heart failure. List only immediate Cause (Final disease or condition resulting in death)	· Kyoce	ardial (or as a consequence	Inta	clion		Least 2 hou
e attending physician and but of use es the bunal-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a consequenca o				
d for use	Part II. Other significant conditions	contributing to death but not re	asulting in the underlyin	o cause given in Part I	23b. Did to	obacco use contri	bute to the cause of de
by ach							Probably 4 Munk
2 shou					24a. Was a perfor		4b. Were autopsy finding available prior to completion of cause of death?
pag Con					1 U Y	es 2 No	1 □ Yas 200 No
this certificate ral director, pag TO Be Co	25. Was case referred to medical axaminer?			26. Place of I	Death (Check only or	10)	-
this central direction.	1 Yes 2 No			DOA Other: 4 Nursing	g Home 5 ☐ Resid	ence 6 Other (Specify)
or death. octor: After th by the funeral iffication:	27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. injury at Work?	28d. Describe h	ow injury occurred	
at Director: After the in by the funering Certification:	3 Suicide 6 Could not l 4 Homicida determined	28e. Place of injury - At building, etc. (Spec	home, farm, sireet, fac city)	tory, office	28f. Location (S City or Town		or Rural Routa Number,
Et hou Funer stely fill dical	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best of my kr miner: On the basis of exsmir and manner stated.	nowledge, daath occurr nation and/or investigat	ed at tha fime, data and pla lon, in my oplnion, death or	aca, and dua to the courred at the time, d	ause(s) and manne late and place, and	er as stated. I due to the cause(s)
within To the comple	29b. Signature and titla of certifier	Tripure	aecii	29c. License number 66	1	Pugual	donth, Day, Year)
6	30. Name and address of person who 5 60 (Well Ra)	completed cause of death (its	em 23a) (Type, Print)	SIREESH WOLL, KO	1-212	PURAI	VENT
State Registrar	31. Data filed (Month, Dey, Year) AUG 1 7 2000	32. Registrar's Sign	gature Soork	á			

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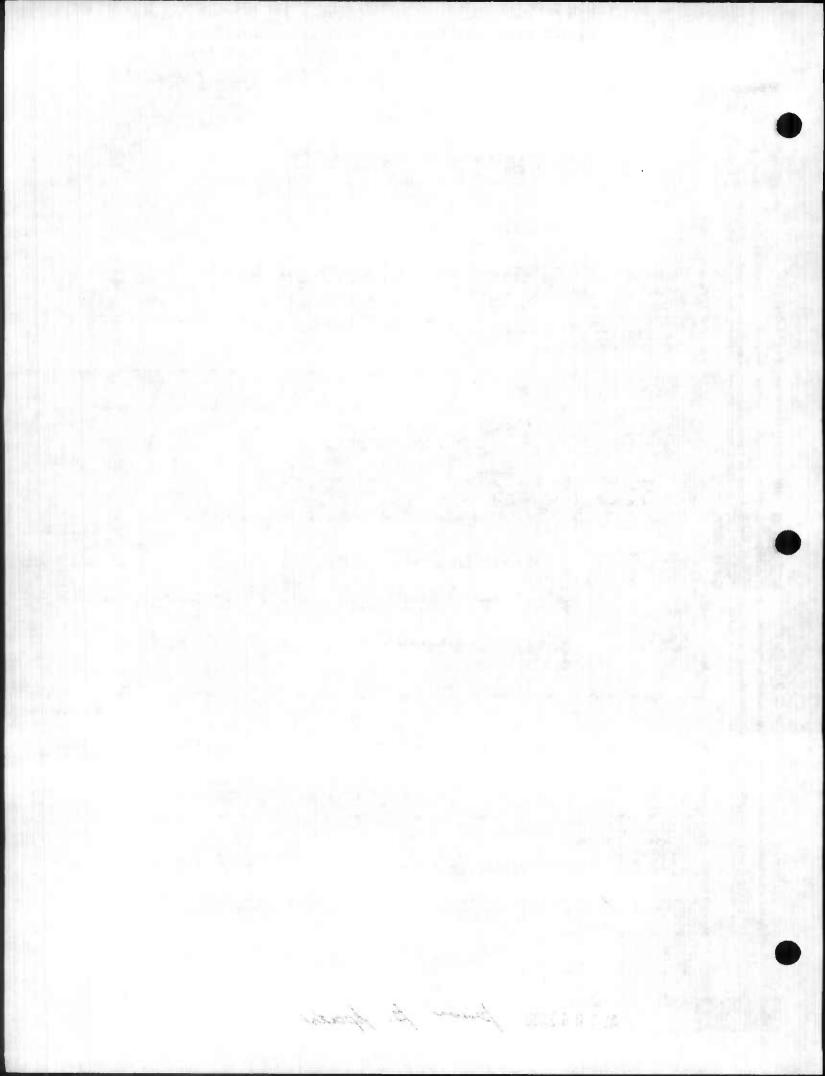
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	of 28a-f show be notified at Director	10e. Street and Nu				POLL	10f. Zip (Code			10g. Citizen of V	What Count	ry?
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	To the Hospital within 24 hours in the Funeral I completely filled Medical Co	29a. Certifier (Check only one)	Certifying Ph		s of examination		estigation,	in my o	opinion, death o		e, date and place,	and due to	the ceuse(s)
0	To the com	29b. Signature and	Tie ?	1					se number	7	July	31,	2000
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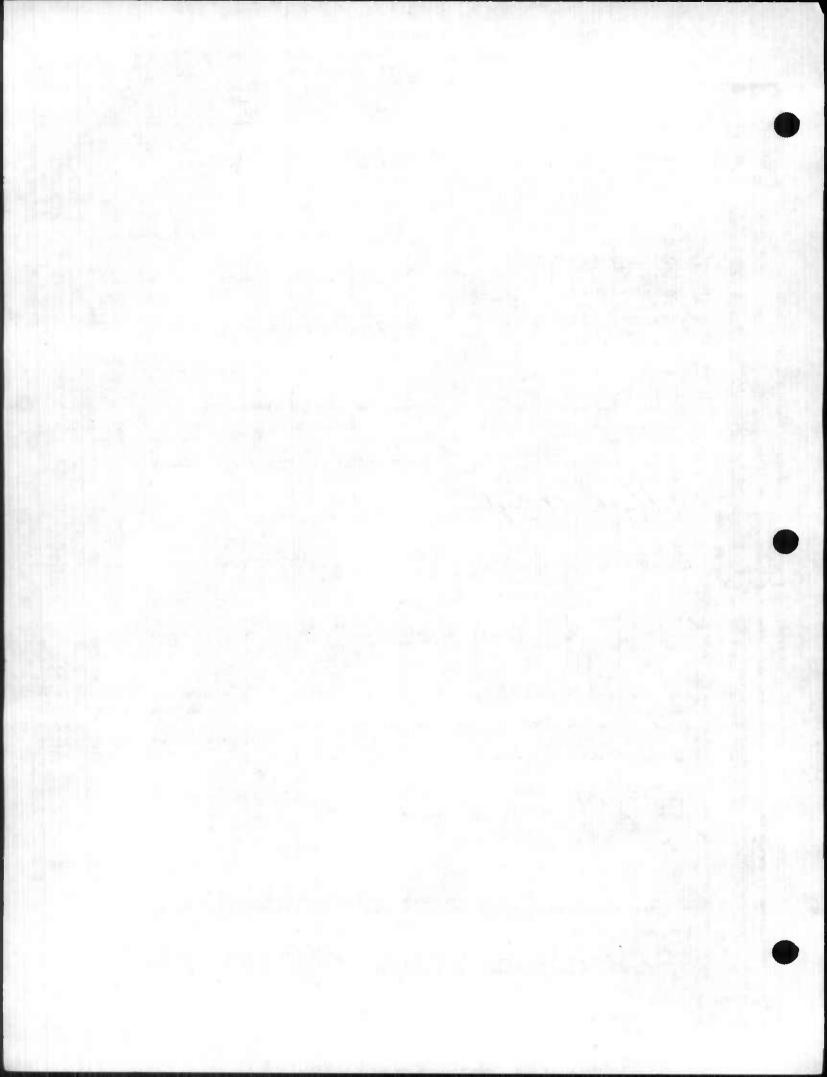
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/Med		JOAN MARIE BRYA	N				AUGUST	1 200	
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anyland show		Usual Residence of Decedant 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yas 2 ※ No
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la l	To B	CHESTER CHARLES	LAUCK			MARIE B	LSHOP		
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		1. Decedent's Name (First, Middle, L	ast)						2. Date of D	eath		3. Time of	Death
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Examine	_	4e. Facility Name (If not institution, g	ive street and number)			4b.	City, Town,	or Location of Dea	h 4c. County	of Death		
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00	0	exeminer? 1 Yes 2 No	Hospital: 1 Inpati	ient 2 🗆	ER/Outpetient	3 DO	Other;	Nursin	ng Home 5□ Res	dence 6 Oth	er (Specify	")	
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s after de	Certification:	3 Suiclde 6 Could not 4 Homicide determined	28e. Place of In building, et	jury - At ho tc. (Specify	ome, farm, stree	et, factory	, office		28f. Location City or To	Street and Numb wn, Stete)	er or Rurai	Route Numb	ber,
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vithin compl		29b. Signature and title of certifier				29c	. License r	number		29d. Date signed	d (Month, L	Day, Year)	
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		30. Name end address of person who	NWT 30	av A	TUROLA	rint)	REET	CA	MBRIDGE	MD	216	13	
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State of Maryland / Department of Health and Mental Hygiene 00 26047.

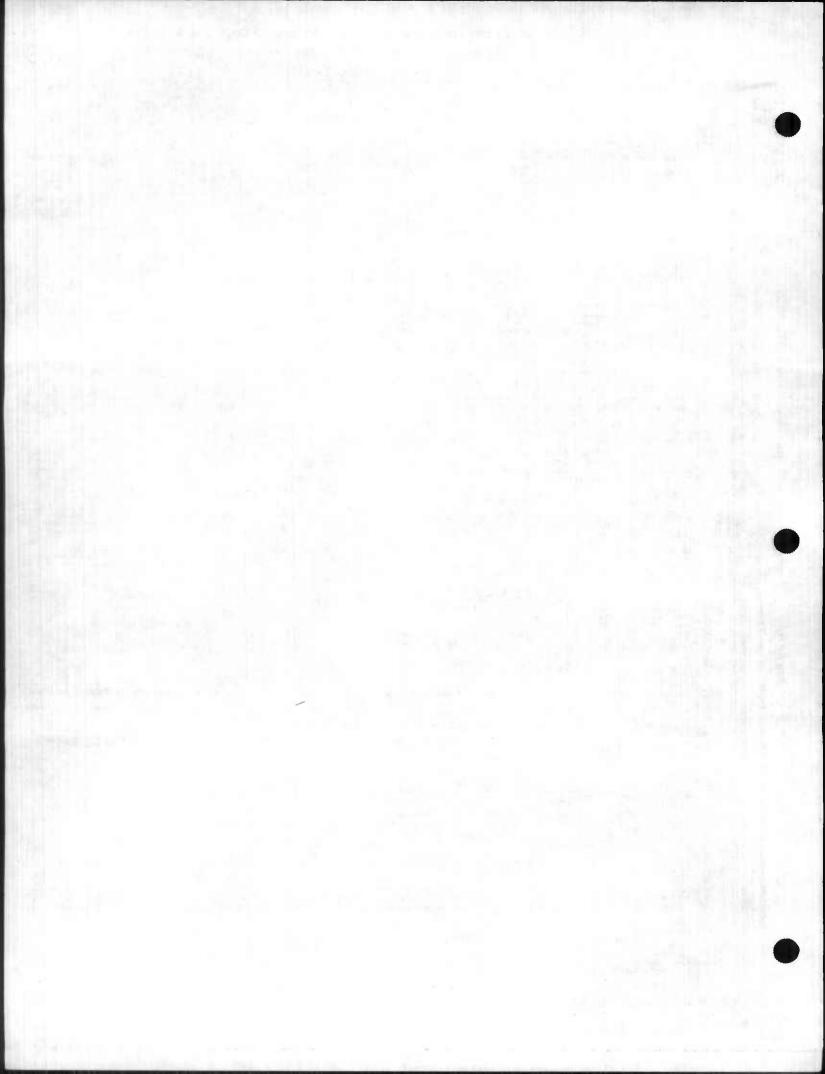
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	/Medica		4a Facility Name (If not institution, give	ooTH re street and number)				4b. City, To	wn, or Lo	cation of Death	4c. County	-	70.0.	
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	and **		10a. State 10b. County	100	. City, Town	or Location						1	Od. Inaide City Limits	
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	28e	Director	Maryland Queen A	Allife	Queen	7	Zip Code				10g. Citizen of V	What Cour	ito/?	
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	er de	Š	11. Meritel Stetus	Armed Forces?	III U,S.	If Yes, s	pecify Cub	en, Mexicar	, Puerto	pecify Yea or No- o Rican, etc.) 14. Race - American Indien, Bieck, White, etc.				
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0	H Ne H		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐		cemetery	, cremetory o	or other ple		1	Dete	20c. Location -			
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Baltimore,	pemil. Peges 1 an Department of Heel Important: If Nam 2 any injury or other page.		21. Signeture of Funerel Service Lice	nsee				ess of Fecili	,					
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	/Medical		Immediate Cause (Finel	Candia	010	000.0	2 101 1	1	re	1		1		
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68760	physician the burie		Cause (Disease or Injury that initiated events	· Multi	org	an t	oil	ure						
89	physics the	edical	resulting in death) Last	Due	to (or es al do	risequenca c	η;							
Box	death certifical attending photograph of for use as to	3		d										
ă	death e atter	clar								1				_
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	es that the death igned by the atte be detached for	4	End-Stage	Renal Dis	sease					10	Yes 2 No	3 Pro	bably 4 Unknov	/n
Records,	signed d be de	Completed by Physician/		Renal Dis Hyperter						24e Wee	an autopsy	24b. W	ere autopsy findings	
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ita		Be	25. Wes case referred to medical examiner?					26. Plece	of Deet	h (Check only c	ne)			
7	2 00	0	1 Yes 2 No	Hospitel:	2 ER/Outp	patient 3	DOA Ott	her: 4 No	ursing Ho	me 5 Resid	denca 6 Oth	er (Speci	(y)	
Division of Vital	eath. or: After th the funeral		27. Menner of Deeth 1 ⊠Natural 5 ☐ Pending	28e. Dete of Injury (Month, Dey Yee	28b. Tie	me of jury	28c. Inju Wo	ry et		28d. Describe I	now injury occur	red		
Ō	Attending ir death. ector: After by the fune	atic	2 Accident Investigation	n		М		Yes 2	No					
Vis	or Attendest Siter deat Director:		3 Suicide 6 Could not be determined		At home, farr	n, street, fec	tory, office			28f. Location (S City or Tox		ber or Run	al Route Number,	
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	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Example)	niner: On the basis of examend menner steted	mation end/	or investigat	ion, in my	opinion, dee	un occur	ed at the time,	uete and piece,	AUG 000 I	(ale ceuse(s)	
	within 2 To the comple	Σ	29b. Signeture and title of certifier	00			29c. Licen:	se number			29d. Date signe			
			1 (1)	(A	11>		12	485			61.0.	30	2000	
		-	30. Name and address of person who	completed cause of death	(Item 23e) (T	ype, Print)	12	107			Juny		2000 Amore, MJ	
			GARY COKE	110000	stee	0 11	aryla	20	Ma	0,010	richon	Bal	fr NI	1
	Stat	a	31. Dete filed (Month, Day, Year)	32. Registrer's S	Signature	4	Pia	1/1	··ce	WI CAN D	75	,5,4	1103	
	Registra		AUG - 2	2000 Dene	/	p. 1	apor	RS						



State of Maryland / Department of Health and Mental Hygiene 00 26048

5 2 9						Certifica	ate of	Death		Reg. No.				
The Memory is a Hope and Part of Part		/Medical	Decedent's Nama (First, Mide		RLEY A.	BRAMB	LE		Month	Dey		2205		
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200 100	A		The Memoria	al Hospita	1	idhday) If Und	ler 1 Year					place (State or Foreign		
MD Caroline 10c. Div. Town or Location 10c. Div. Town or Location 10c. Div. Signal and Number 10c. Div. Signal and Num	8		215-58-7240			Month			. (Month, C	, 1945	De 1	aware		
1		0 8 m		у	10c. City, Tov	vn or Location						10d. Inside City Limits		
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Securities in terminate Control of State		23s or unt be r								United	St	ates		
College (1-4of 6-) College (1-4of 6-) Prep Cook	le 020	D	1 Naver Merried 2 XMe	rried 1 Yes 25	€ No				Specify Yes or N rto Rican, etc.)		ck, White,	etc.		
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17 Fether's Name (Prizz, Middle, Lest) 18 Mares Name (Prizz, Middle, Macker Summer) 18 Macker Name (Prizz, Middle, Middle, Macker Name	ra 121	Pan He	Elementery/Secondary (0-12)	College (1-4o	or 5+)			d)	Restaurant					
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Physician Physician Examiner Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.			23a. Pert1. Enter the disease, or heart failure. Lis	or complications that caus	ed the deeth. Do	not enter the m	oda of dyi	ng, such es cerdia	c or respiretory	errest,		Approximete		
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29e. Certifier (Check only one) 29b. Signafura and fitte of certifiar 29b. Signafura and side of certifiar 30. Nema and address of person who completed ceuse of death (Item 23e) (Type, Print) Nancy Snow, M.D., 219 Washington St., Easton, MD 21601	on of	aling Phy h. After this funeral funeral	1 Neturel 5 Pend	1										
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Nancy Snow, M.D., 219 Washington St., Easton, MD 21601		To the comp	29b. Signatura and fittle of certifit	Dern -	ment	2)	9c. Licans	sa number 205 33	69	29d. Deta signa 8 / 2	od (Month	, Day, Year)		
Nancy Snow, M.D., 219 Washington St., Easton, MD 21601			30. Name and address of percon	who completed course of	f death (Item 22a)	(Type Print)								
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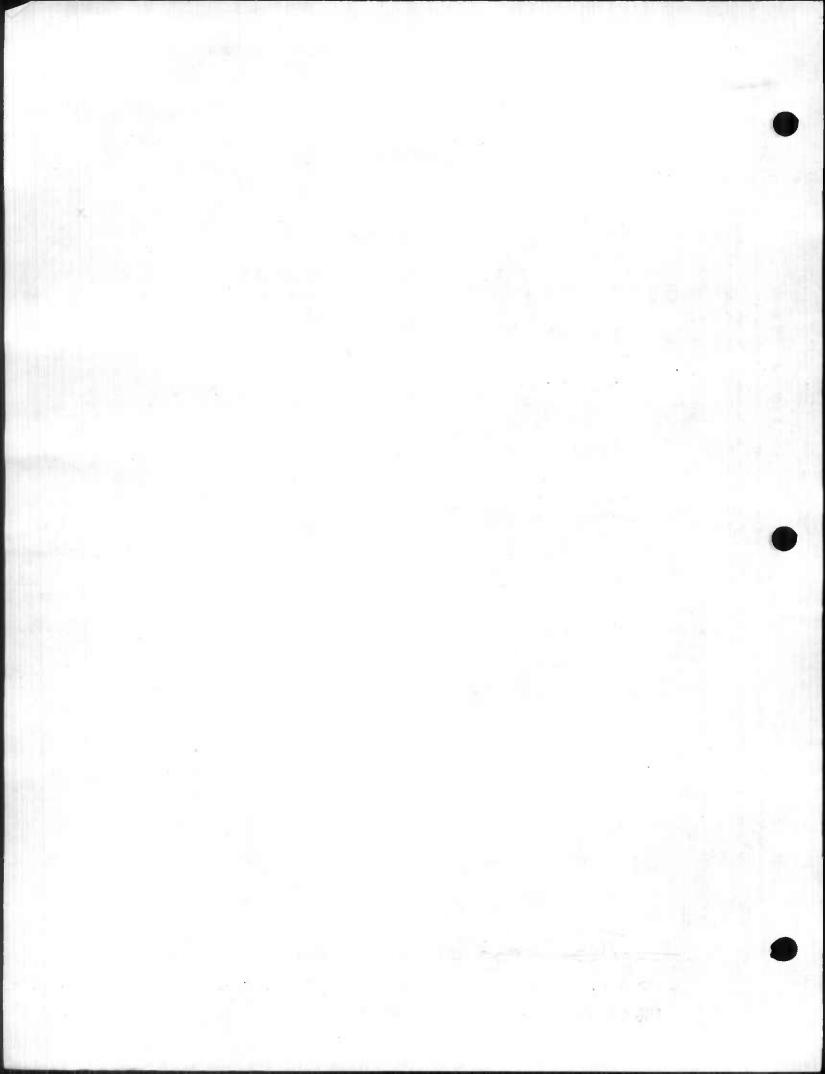


State of Maryland / Department of Health and Mental Hygiene

26049 Certificate of Death

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dical	4a Facility Name (If not institution				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			4	b. City, To	own, or L	ocalion of De		4c. County		
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	Usual Residence of Decedent 10a. Stete 10b. Count	v		-	10c. City, Tov	m or Lov	oalion		-						and Incide Oite
					TOC. City, TO	VII OI LOC	Callon								10d. Inside City
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To B	Michae	el B	obvk								Anna	War	nko		
-	19a. Informant's Name/Ralation				10	h Mailie	n Address	(Street	and Nimh	er or P	al Route Nur			State	Zin Code1
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è	21. Signature of Funerel Service Licensee. 22. Name end Address of Fecility									tv					
9	Da Show = 1. t	on &	Son F	une	ral Ho	ome,	P.A.								
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.											000	0766		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#16b perFHG786 8/18/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Yes **Physician** 29, 2000 RUTH B. BEBPER July 7:20 PM /Medical 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1958 Glen Cove Road Darlington Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociei Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Hours Months 1 M 2XX 218-22-3198 87 Yrs Director 9/23/1912 Virginia Usuel Residence of Decedent the Maryland 10c City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumetic svent, tre Madical Examinet must be notified at MD Harford Darlington 1 Yas 2 7 Director 10e. Street and Number 10f Zip Code 10g Citizan of What Country? 1958 Glen Cove Road 21034 USA Funeral deeth Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Was Decedent Evar in U.S. Armed Forces? Black White atc. filed within 72 hours after 1 Yes WNo 1 Naver Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ Yes Specify: SpeciWhite Aq XXWidowed 4 ☐ Divorcad Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadant's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: If Item 27 is marked other than any Injury or other traumetic avent Elemantery/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be Commodore Hawkins Eliza Reed 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Neme/Reletionship (Type, Print) Robert H. Bebber- son 1958 Glen Cove Rd., Darlington, MD 21034 Baltimore. 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 Kirial 2 Cremetion 3 Removel from State Darlington Cemetery 8/1/00 DArlington, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signeture of Funeral Service Licenses Harkins F.H.Inc., 600 MAinSt., Delta, PA well 17314 Dot enter the mode of dying, such as cardiac or respiratory arrest, Enter the diresse, or complications that caused the death. Approximeta Interval Between Onset end Deeth **Physician** myocardial infarction /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner perten siar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting In death) Lest pue the buriel-tran (or as e consequance of) Box 68760 physician 8 Physician/Medical Due to (or es a consequence of) for use as 93 signed by the e 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yas 2 No 3 Probebly 4 Unknown by 24b. Ware eutopsy findings avellable prior to 24a. Was an autopsy Completed completion of causa of death? page 2 hes 1 Yes XXNo 1 Yes 2 No certificate Division of Vital or Attending Physician: effer death. Director: After this certific 25. Wes case raferred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home XX Residenca 6 ☐ Othar (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Laneturel 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending invastigation 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Spacify) in by 4 ☐ Homicide 24 hours e Funeral D 152 xartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

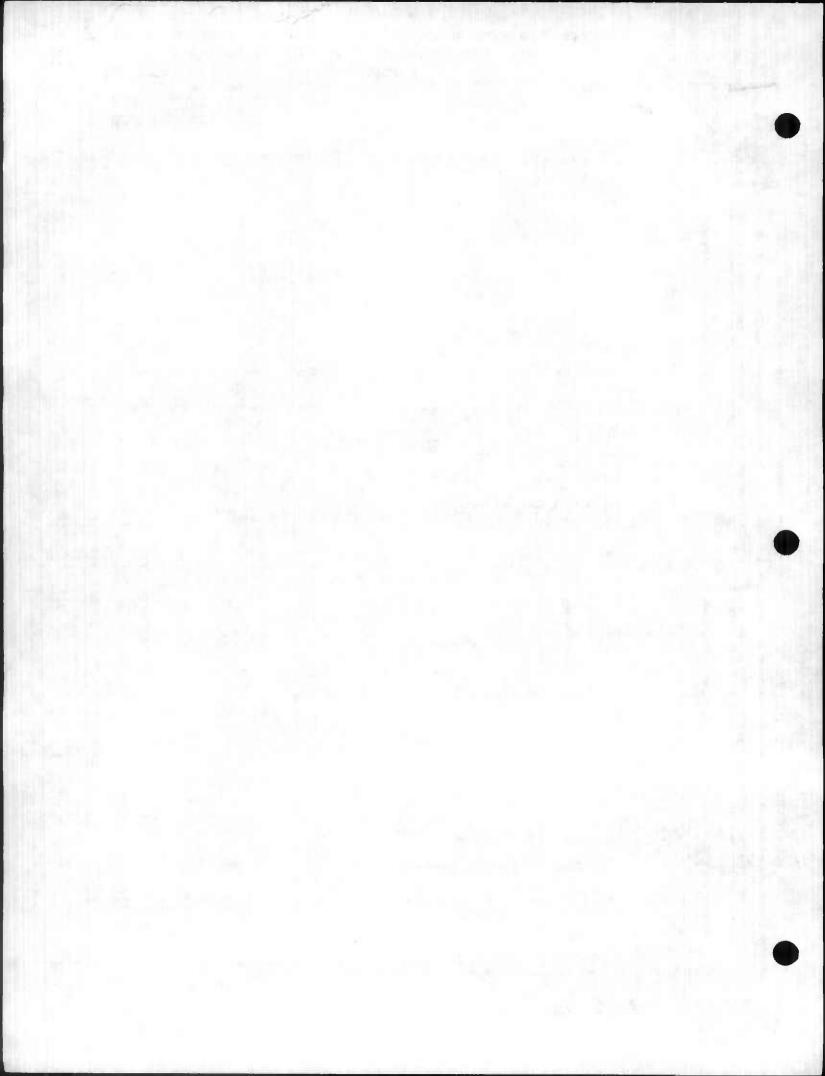
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29e. Certifier Medical (Check only one) within 2 and mennar stated. 29b. Signetura eng vitte of Artifiar 29c. License number 29d. Date signed (Month, Day, Year) 7/31/2000 036425 0 30. Nama and address of person who complated causa of daeth (Item 23a) (Type, Print) Dr. Adam Faill, 206 Hays St, Bel Air, MD 31. Date filed (Month, Day, Yaar) 32. Aegistrar's Signatura State Registrar AUG 2 2000

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WARFERD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 2 6 0 5 1

					C	ertificate of	Death	Re	ng. No.	2000	1
8			1. Decedent'a Name (First, Middle, Last)					2. Date of Death	h	3. Tima of Dea	ath
6		Physician /Medical	COAMPHAND IV. DI	iettner				July	30°, 200	2:20 A	AM
a		Examine	4e Facility Name (If not institution, give s	street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of		
4			Gilchrist Center				Towson			timore	
30th		Funeral Director	5. Social Security Number 6. Sex 212-05-1290	7. Age (In y	rs. last birthde Yrs.	Months Dave		8. Dete of Birth (Month, Day, July 24,	, 1905	9. Birthplace (State or Fo Country) Maryland	oreign
T		and a	10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City L	imits
13		Manylan f show	Maryland N/A			Baltimo	re.			1 DYes 2	□ No
1 1		or 28a	10a. Street and Number			10f. Zip Code		10	0g. Citizen of Wh		
w		23a	1651 E. Belvedere	Ave.		2123	39		u.	S.A.	
ATHERUNE	21215-0020	72 hours after death with the Manyland natural; or items 23s or 28s-f show deat Exemples must be notified at which has Exemples and hardward Directors.	11. Merital Stetus 1 1 Never Married 2 Married 3 Wildowed 4 Divorced	 12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 	n U,S.	3. Was Decedent of if Yes, specify Cu 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Sp ben, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indien, Whita, etc. White	
F	5-0	72 h	15. Decedent's Educ (Specify only highest grade		16a. De (G	cedent's Usual Occi	upation a during most of work ad)	ing	16b. Kind of Busi	ness/Industry	
4	121	be filed within 72 ho tal Hygiene. d other than "naturi event, the Medical Bac Commission"	Elementery/Secondary (0-12)	College (1-4or 5+)		s. DO NOT uso rotir omemaker	ed)		Own	Home	
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,	lan	Mental Mental arked o	(unknown)					lunknou	on)		
of	Maryland	2 should be filed a sand Mental Hygier Ie marked other traumatic event, the To Re Co.	19a. Informant's Name/Relationship (Typ.	pe, Print)Ponsanal	19b. M	ailing Address (Street	et and Number or Run	al Route Number,	City or Town, S	lete, Zip Code)	
3		Health am 27 learn am 27 le	Mr. Charles Warge	o Rep.	29	30 E. Bal	timore St.	, Baltur	iore, Mu	21224	
F		of Health of Health I fram 27 r other tr	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		b. Plece of Dis cemetery, o	sposition (Name of crematory or other pi	(ece)	Dete 2	20c. Location - C	ity or Town, State	
15	E E	ment of lands of lands of lands or of	4 □ Donetion 5 □ Other (Specify)	G	reen M	ount Crem	atory 8	12/00 E	3altimor	e, Maryland	l
BMS	Baltimore,	permit. Pages 1 and 2 should be filed Department of health and Mental Hys Important: if Ism 27 is marked othe eny injury or other traumatic event, page.	21. Signature of Funerel Service License Bucin G. U	ceillen		Schimune Baltimor	ek Funeral	Home, I.	nc.,9705	Belair Rd.	
			23a. Part1. Enter the disease, or complic shock, or heert failure. List only on	cetions thel caused the decause on each line.	eeth. Do not	enter the mode of dy	ying, such as cardiac	or respiratory arre	ist,	Approximete Interval Betwee	
	4	Physician /Medical Examiner	Immediate Cause (Finel disease or condition	Aart	EC .	steno	sis			Search Dear	2)
			resulting in death) a	Due to	o (or as a con	sequenca of):					
		ficate be assected physician and s the bunal-transit	6 b							1	
	,	ifficate be asscuted g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to	o (or as a con	sequenca of):					
5	68760,	ifficate be a g physician as the bunic	Cause (Disease or Injury that initiated events	Due to	o (or es e cons	sequenca of):				1	
F		E 0 4 =									
0	Вох	attendin for use	d								
y	0.	the death cer y the attendir sched for use	Pert II. Other significant conditions cont	tributing to death but not	resulting In th	e underlying cause (given in Part I.	23b. Did to	bacco use cont	ribute to the causs of d	Jeath?
8	0	~ 0 " 7	Covonary Ar	tery dis	ease			1 □ Ye	2 No	3 Probably 4 Uni	known
	Records,	signed be del						24a. Wes ar	n autonsy	24b. Were autopsy findi	lings
	202	law requires it as been sign as 2 should be						perform	ned?	available prior to completion of caus of deeth?	-
-1		The lay						1□ Ye	es 2 XNo	1 ☐ Yes 2 ☐ No	
0		certificate rector, pag	25. Was case reterred to medical				26. Place of Deat		,	10 163 20 160	
1=	<u> </u>	Physician: The lave this certificate has ral director, page 2	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	2 ☐ ER/Outpe	tient 3 DOA	Whor	me 5 Reside		(Specify) OSPC	ice
1		£ 5 m	27. Manner of Death 1 2Natural 5 Pending	28e. Date of Injury (Month, Day Year	28b. Time	e of 28c. Inj	ury at ork?	28d. Describe ho	w injury occurre	d	
	sio	ttending death. death. tor: After / the fune	2 Accident investigation 3 Suicide 6 Could not be				☐Yes 2☐No				
	Division	s after day od in by	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sipe		street, factory, offic.	a	28f. Location (Sti City or Town	reet and Number i, State)	r or Rural Route Number	Γ,
		To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the tuners Medical Certification:	29a. Certifier Descripting Physics (Check only one) 2 Medical Examin	Iclan: To the best of my leer: On the basis of exam and manner stated.	knowledge, de Ination and/or	eeth occurred at the r Investigation, in my	time, date and placa, opinion, death occur	and due to the ca red at the time, da	tuse(s) end men ate and placa, ar	ner as stated. id due to tha cause(s)	
		To the to	29b. Signature and title of certifier	10.0		29c. Lice	nse number		-	(Month, Day, Year)	
			If thishon	young.	us)	16	13 aw	-	1-173	0,2000	
			30. Name and address of person who con	mbleted cause of the (I	Item 23a) (Туј 7d (N-Chi	ales St.	Bala	to. Mo	1 2120%	
		State	31. Date filed (Aph GDa Year) 2000	Begintar's Si	gnature 6	lan .	1,				



State of Maryland / Department of Health and Mental Hygiene

26052

	MALE BUILDING			Cei	TITICA	te or	Death		R	eg. No.			-		
Physician	Decedent's Neme (First, Middle, L James Day:		OB						2. Dete of Dee Month July 30	Dev	Yeer	3. Time of 5:45			
/Medical Examiner	4a Facility Name (If not institution, gi		_			wn, or Lo	cation of Death	4c. Count		1	L • Fl •				
	Genesis Elderca	re at Lay	hill				Silve				gome	ry			
	409-46-4753	Sex 1 M 2 □ F				er 1 Yeer Deys		Min.	8. Defe of Birth Month Day May 13,	1922	9. Birth Cou Sout	h Caro	or Foreign lina		
show rd.er	Usuel Residence of Decedent 10a. State 10b. County			10d. Inside C	ity Limits										
Director	Washington, D. C. 10e. Street end Number 10g. Chizen of									1 √ Yes 2 No					
natural; or Itama 23a or 28a-1 ahow dical Examiner must be notified at sted by Funeral Director	1921 Bunker Hi	11 Road			101. 2	200)18			intry r					
	11. Merital Sfetus	12. Wes Decede	enf Ever in U,S	S. 13.	Nes Dec	edent of	Hispanic Ori	gin? (Spe	ecify Yes or No-		Race - American Indien,				
Š	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Force 1 7 Yes 2 If Yes, Give Yeer or Dete	□ No	200		2 ₩ No	ben, Mexicar Specify:	i, Puerto	Rican, etc.)	Speci	ock, White	lack			
eted	15. Decedent's 8 (Specify only highest gi	ducetion rede completed)		18e. Deced	kind of v	rork done	durina mos	t of worki	ing	16b. Kind of E	Business/I	ndustry			
Completed	Elementery/Secondary (0-12)	or 5+)	life.	DO NOT	use retire	9d)		U.S. Government							
	17. Father's Neme (First, Middle, Las	t)	т 0.			0	, , , , ,	r's Neme	e (First, Middle,						
o Be	James David Ca	rlton, Sr					La	ura .	Jones						
_	19e. Informent's Name/Reletionship	(Type, Print)		19b. Meilir	ng Addre	ss (Stree	at and Number	er or Aura	al Route Number	, City or Town	, Stete, Z	ip Code)			
	Willette M. Carl	ton/ wife			_		Hill R	d. W	ashingto						
	20a. Method of Disposition 1 Burial 2 Cremetion 3 Remove from Stete 4 Donation 5 Other (Soecity) 20b. Plece of Disposition (Name of cemetary or other plece) 1 Lincoln Crematory August 1, 2000 Brentwood, MD														
-	22. Name end Address of Fecility Ft. Lincoln Fune: 3401 Bladensburg Rd. Brentwood, M														
	23a. Part : Enler the diese e, or cor shock, or heart failure. List only	Approximate Intervel Between Onset and Deeth.											ween		
an al er	fmmediate Cause (Finel disease or condition	e. Sep	e. Sepsis										1 week		
	resulting in death)		Due to (or es a consequence of);										1 week		
Examiner		Pne b	Pneumonia												
	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	c. End	Due to (or es a consequence of): Endocarditis												
v/Medicai	that initiated events resulting In death) Lest	l d.	Due to (or	es a conseq	uence of):									
cian		U.													
Physician	Pert II. Other algnificant conditions	contributing to death but not resulting In the underlying cause given in Pert I.							23b. Did tobacco use contribute to the				of desth?		
by Pt									101	40110	3 C FF	July 7	, JHAROWA		
Completed t									24e. Wes a perfor	n autopsy med?	8	Vere eutopsy vailable prior completion of of deeth?	to		
THO.									10Y	es XXNo	100	3.7] No		
BeC	25. Wes case referred to medical						26. Place	of Deetl	h (Check only or	ne)					
To	examiner? 1 Yes 2 No	Hospitel: 1 ☐ Inp					g Home 5 Residence 6 Other (Specify)								
	27. Manner of Deeth 1 Neturel 2 Accident 5 Pending investigetion		28b. Time of Injury				1	28d. Describe how Injury occurred							
Certification:	3 Suicide 6 Could not determined	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)							28f. Location (Street and Number or Rurel Route Number, City or Town, State)						
edical (hysician: To the be miner: On the basi end menne	s of examineti										s)		
Medical Cert	29b. Signeture and fitte of certifier	1000.	- Or	n.	2		nse number		1	9d. Dafe sign	ed (Month	n, Day, Year)			
1	Housen	alle	-EU	M	0	DE	385	62	2_	mag	1, 2	2000			
1	30. Neme and address of person who Anurita Mendhir	atta, M.D	of deeth (Item). 2401	23a) (Type, Resea	Print)	B1vc	d. #34	0 Ro	ckville	, MD 20	0850				
State	31. Defe filed (Month, Dey, Year)	22. Reg	isfrer's Signet	ure	1.										

130 0 30

State of Maryland / Department of Health and Mental Hygiene 00 26053

					Cei	tificate o	f Death		Reg. No.	0	2000	J			
Chara	ofon	1. Decedent's Name (First, Middle	e, Last)	2. Deta of De	Day	Year	3. Time of Dea	ath A							
Physi /Med		Jessie J	ames Carn	ey				July	25 0	2000	3:401	Foreign rolin Limits SANo death? Inknown Indings Usa			
Exam		4a Facility Name (If not institutio	n, give street and num	nber)			4b. City, Town, or	Location of Deat	h 4c. County	of Death					
		Doctors Commun					Lanham		Princ						
Funera Directo		5. Social Security Number 243-20-0153	6. Sex 1 M 2 □ F	7. Age (In yrs.	iast birthday) 79 Yrs.	If Under 1 Ye	ar If Under 24 Hrs ys Hours Min.		th 28,192	9. Birthpl 1 No	lace (Stata or Fo	oreign :olin			
pu &		Usuel Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10	Od. Inside City Li	imits			
death with the Maryland	ector	Maryland Prince	e Georges	Gr	eenbel				40a Chinas at l	After Cours	1 □ Yes 2 ₹	Foreign roling Limits and Modern Polings usa			
CATNEL O after death with the after death d	Funeral Director		nbelt Rd.	# T1		10f. Zip Code 207	770		10g. Citizen of V		try r				
Z 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	by	11. Maritaf Stetus 1 Nevar Merried 2 Mar Widowed 4 Divorced	ried XXX Yes	12. Was Decedent Ever In U.S. Armed Forces? X X X Yes 2 □ No 17 Yes, Giva Year or Dates: 1943-45			of Hispanic Origin? (Suban, Mexican, Puar to Specify:	Specify Yes or No to Rican, atc.)	y Yes or No- can, atc.) 14. Race - American Black, White, et						
5 17 E	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Educetion st grada completed) College (1	-4or 5+)	(Give	dent's Usual Oct kind of work do DO NOT use rel housema	ne during most of wo ired)	rking	16b. Kind of B						
d 21 d 21 Hygienether the	Co	6			ware	. Housema					CIIC				
Due Hall	8	17. Father's Name (First, Middle,						me (First, Middle	- CS P.M.	10)					
aryla should nd Mer marks	2	Johnnie (ine Plu		04-1- 71-	0-4-1				
Maryland d 2 should be file th and Mental Hy 7 le marked other traumatic event	р	19a. Informant's Name/Relations atricia Hughes					et and Number or R								
SSIC JA. Ore, Maryland 2 ore that 2 should be filed of Health and Mental Hyping flam 27 is marked other was other traumatic event,		20a. Method of Disposition	Daughter	20b. 1	Place of Dispo	sition (Name of		Date	T1 Greenbelt, MD 20770 Date 20c. Location - City or Town, State						
Baltimore, Maryland : permit. Pages 1 and 2 should be filed proportion of Health and Montal Hymportant: if them 27 is marked other with Injury or other traumatic event,		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Ft.	Linco.	Ln Cemte	31, 2000 Brentwood, MD								
Ball Depart Import		22. Nama and Addrass of Facility Ft. Lincoln Funera 3401 Bladensburg Rd. Brentwood, MD													
CF THE		23a Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate interval Between													
Physician /Medica Examine	1	Immediate Cause (Final disease or condition resulting in death) Prostate Concer													
	ē e			Due 10 (or as a consec	juence of):				1					
8760, sate be executed thysician and the burial-transit	Examiner	Sequentially list conditions	b	Due to (or as a consec	juence of):									
O, o exex	EX	Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury													
68760, rifficata be exen ng physician a eas the burial-	edical	that initiated events resulting in death) Last	С.	Dua to (d	or as a conseq	uance of):									
0 1	¥											Genth? Coreign rolin Limits Choo death? nknown dings usa o			
30) Ith ce	an/		d												
O. The adea	Physician/M	Pert II. Other significant condition	23b. Did tobacco use contributs to the cause of death?												
ds, P.O. Box ires that the death cer signed by the attendin d be detached for use	by Phy	Hyper	-tenti	1 Yes 2 No 3 Probably			bebly 4 Uni	known							
il Records, P.O. Box The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Completed by			8-4				24a. Was	an autopsy omed?	COL	ere autopsy findi aileble prior to mpletion of caus death?				
f Vital Rec	mo.							10	Yes 2 No	10	Yes 2 No	>			
Vitai I liclen: The certificate rector, pag	Be	25. Was case referred to medica examiner?					26. Place of De	eth (Check only	one)						
Of V Physic this ce	To	1 Yes 2 No	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA	Home 5□Res	ome 5 Residence 6 Othar (Specify)							
ng Pt fler th		27. Manner of Death 1 ■ Netural 5 □ Pendir	28a. Dete o	of Injury th, Day Year)	28b. Time o Injury	28c. Ir	njury at Vork?	28d. Describe how injury occurred							
Division of Vital Records, P.O. Box To the Hospital or attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical Certification:	2 Accident invasti 3 Suicide 6 Could 4 Homicide	not be 28a. Place	M 1 Yes 2 No					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
DIVI To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	dical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
To the within 2 To the comple	M	29b. Signature and title of certifia				29c. Lica	anse number		29d. Date signs						
00		Mousinfe	I han	m	MD	D	43691	0	07/		2000	,			
(3)			who completed cause SHAMM1	e of deeth (Iter	8118	GOOD 1	Luck RD,	LANH	Am, M	0 2	2706				
s	tate	31. Date filed (Month, Day, Year)	00 3e. R	egistrar's Signi	ature	1									

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	nt's Neme	(First, Middle	Idle, Last	(t)				71111001				2. Dete of De			3. Time of Dee		
ਜ਼ਰ	JDEMC	CE A.	CF	нтс	ST.EV							Month	2 Day	200	y) 8:120		
		not institution				ber)	•			4b. City, To	wn, or Lo	ocation of Deal		ounty of D	Death		
e7 curity	RTH ecurity Num	1 AR	EUN 6. Se	U D)EL	HOS.	PITO last birthday	If Unde	r 1 Year	G/E/		B. Date of Bi	rth	A C.	OUNTY Birthplece (State or Fo.		
	32-99 idence of D		18	Ďм :	2 F 7	64	Yrs.	Months	Deys	Hours	Min.	JAN.	28 19	936	MARYLAND		
10a. State 10b. County 10c. City, Town or Location											10d. fnside City Li						
MARYLAND ANNE ARUNDEL ODENTON												1 🛛 Yes 2 🗆					
et and Number 10f. Zip Code							10g. C		g. Citizen of What Country?								
	TA DE	RIVE			21									USA			
RITA DRIVE 11. Marital Status 12 Never Married 2 Merried 3 Widowed 4 Divorced					12. Wes Decedent Ever in U.S. Armed Forces?			Was Dece tf Yes, spe	dent of h	lispanic Ori an, Mexicar	gin? (Sp i, Puerto				kmerican tndien, Vhita, etc.		
					Yes, Give		7.00	1 ☐ Yes	1 ☐ Yes 2 ☑ No Specify:					Specify: BLACK			
Dewc					reer or Det	es:	16a Door	donte Heu	al Occur	etion			16h Kind	of Rusins	Business/Industry		
-	(Specify		nest grad	de com	ucation de completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of wollife. DO NOT use retired)				ing	TOD. KING	OI DUSING	ssamigustry		
Elementery/Secondery (0-12) 10th				C	College (1-4	4or 5+)		TREE TRIMMER					GASPRICH		TREE SE		
		First, Middle,	e, Last)		0		110	<u> </u>	1/ 1/ 1/		r's Nem	e (First, Middle					
17. Fether's Name (First, Middle, Last) JOHN F.										MA	RTH	A CON	TEE				
		me/Reletions					19b Mei	ing Addres	s (Street				Route Number, City or Town, State, Zip Code)				
			IST							HILL					MD. 2106		
	BEL!		151.	EK	/	20b. I	Plece of Disp cametery, cre				DIC.	Date			on - City or Town, State		
riai 2	uriai 2 🗆	Cremetion			vel from S						v 7	/31/00	CAM	BRIT			
4 Donetion 5 Other (Specify) WILSON MEM. CEMETERY 7/31/00 GAMBRILLS												JEO, HD.					
21. Signature of Funerel Service Licansee 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A.																	
A Reese MOD 483 821 WEST ST. ANNAPOLIS, MD											21401						
te. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.									errest,		Approximate Interval Between						
Immediate Cause (Finel disease or condition resulting in death) S. MYOCARDIAL INFARCTION Due to (or as a consequence of):																	
				b(Con	DNAR	Y HE	HER	Y,	DISE	458	د					
Sequentially list conditions Due to (or es a consequence of):																	
Cause Chiseses of Injury Chiseses of Injury Cause Chiseses of Injury Cause Chiseses of Injury China																	
death	n death) La	ast				Due to (or es a conse	quenca of):									
			-	d													
	Pert ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.									l.		Old tobacco use contribute to the cause of dea					
r sign										1 Yes 2 No 3 Probably 4 Unkn							
r sign	24a. Wes an auto								s an autonsy	psy 24b. Were autopsy findings							
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se reference of Desturel	ner? es 22 Ne er of Death eturel ecident	investi	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number City or Town, Stete)											Num <i>ber</i> c	or Hural Houte Number,		
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sse reference of Description of Desc	ner? es 2 Ner of Death sturel ecident uicide omicide fier 1, ek only 2	6 Could determ	mined	niner: C	On the bas	sis of examine	owledge, dee etion and/or i	th occurred	d at the ti	me, dete ar	nd place, ith occur	end due to the	e cause(s) ar	nd manne laca, and	er as stated. I due to the cause(s)		
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se reference of the second of	es? 2 No. or of Death sture! coident uicide comicide filer 1, ck only 2	investi 6 Could determ	ying Phy at Exami	niner: C	On the basend menne	sis of examiner steted.	etion and/or i	nvestigetion 29	n, in my	opinion, dea	nd place, ath occur	end due to the	, dete end pl	laca, and	due to the cause(s)		
se refe er? ; 25 of Dea	ner? es 22 No er of Death eturel	investi	ld not be	28	8e. Plece o	of Injury - At h	nome, ferm, s	treet, facto	ry, office					Num <i>ber</i> o)[

State Registrar

30. Name and address of person who po

32. Registrer's Signeture

100 F 4 5000

State of Maryland / Department of Health and Mental Hygiene 00 26055

	Certificate of Death Reg. No.										
	1. Decedent's Nama (First, Middle, Last)						2. Date of Deat		A second	3. Time of Death
Physician	John Robert Co	nlev						Month August	2, 200	Year	11:20 AM
/Medical	4a Facility Name (If not institution, give					4b. City, To	wn, or Lo	cation of Death	4c. County		11.20 AH
Examiner	1902 Marconi Cir					Anı	napo:	lie	Anne	Arund	01
	5. Social Security Number 6. Se		n vrs. last birthde	(V) If Unde	r 1 Year	If Under		8. Date of Birth (Month, Day,			
Funeral Director		M 2□ F 77	Yrs.	Months	Days	Hours	Min.	June 4,1	Year) .923		lace (State or Foreign try) York
pu k	10a. State 10b. County	10	c. City, Town or	Location						1	Od. Inaide City Limits
or 28a-f sho be notified a	Maryland Anne Aru	indel	Annaj								1 ☐ Yes 2 💆 No
	1902 Marconi Circl	.e			p Code 2140	1			0g. Citizen of N USA	Whet Cour	itry?
3 28 3	11. Marifal Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1. Lives 2 □ No If Yes, Give Year or Dates: 19		3. Was Dece If Yes, spe 1 ☐ Yes			gin? (Spi n, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	an Indian, efc. ite	
bed bed	15. Decedent's Edu	ication	16a. De	cedent's Usu	al Occup	pation			16b. Kind of B		
ed within 72 ho ygiene. ser then "natur 4, the Medical Completed	(Specify only highest grad		(Gi	ve kind of w	ork done ise retire	during mos d)	t of work	ing			
the sense	Elementery/Secondery (0-12)	College (1-4or 5+)	Pu	irchas	ing	Agent			Elect	ronic	S
d 2 should be filed within 72 hours at th and Markel Hygiene. T is marked other than "natural", or froumstic event, the Medical Exam To Be Completed by F	17. Father's Name (First, Middle, Last)						er's Neme	First, Middle, I	Maiden Suman	ne)	
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ermit. Pages 1 and Separtment of Heatl Important: If item 2 ity Injury or other ISSs.			20b. Place of Dis			CIIC	re Ai		20c. Location		
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 00 26057

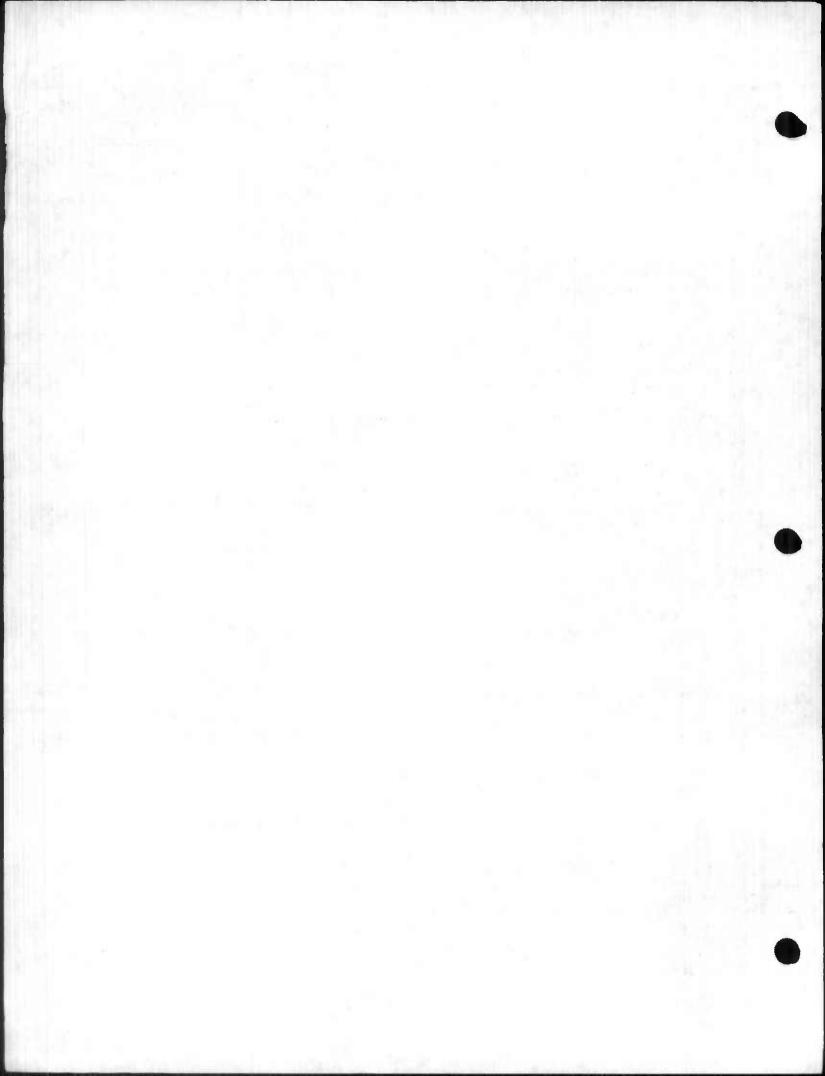
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State of Maryland / Department of Health and Mental Hygiene Kenny Costello

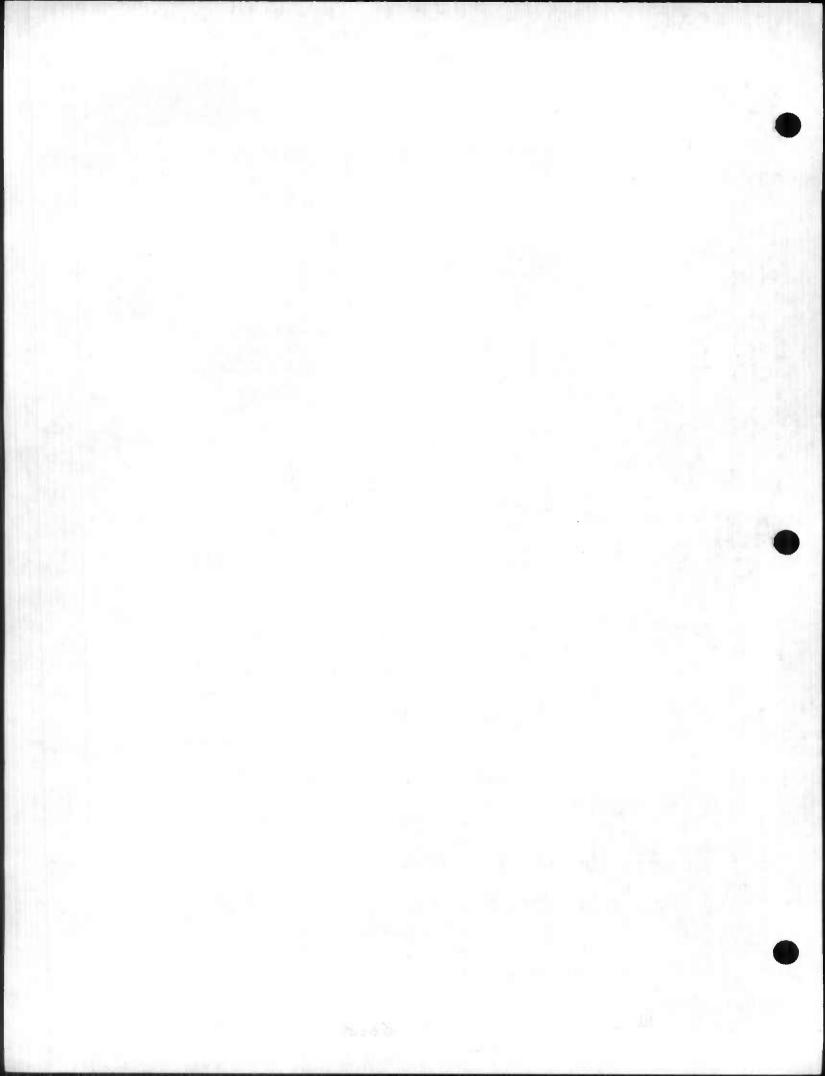
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he Funeral Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit and carried in by the funeral director, page 2 should be detached for use as the burial-transit and carried in by the following the carried in the	Sequarif any, causa. Causa Causa Causa Causa 27. Mar 27. Mar 27. Mar 20. 3 Causa 28. 3 Causa 29a. Ca	s casa refarred to med minar? Other eignificant conditions (againg to immadiate Entar Underlying (Disease or injury lated evants ig in death) Last Other eignificant conditions (against the conditions) S casa refarred to med minar? I yas 2 \(\subseteq \) No mar of Death Netural 5 \(\subseteq \) Per inversions (against the conditions) Suicide 6 \(\subseteq \) Could determine (against the conditions)	ditions co	b	Du D	a to (or as bot resulting 2 ER/ (aar) FC At home, Specify) RI ny knowlectamination	a consequence a	and and and analysing of A by Maat, factor vestigation	COC : : causa gi OA Ot 28c. Inju Wc 1[ry, office I at tha that ha, in my Cc. Lican	26. Placa thar: 4 Num ry at 1 1/4 S 2 M h ime, data and opinion, deet is a numbar	IN'	23b. Did to 1 Y 24a. Was a perior 1 Check only or ma 5 Raside 28d. Dascribe he 28f. Location (Si City or Town GLEN BU end due to the c red at tha time, d	n autopsymed? as 2 ance 6 pow injury of UNKI (treet and in, State). UNKI (treet and pieces) are eta end pieces) are eta end pieces.	No 3 No 3 No 2 No	onset bute to the eavailable complet of death 1 Days (Specify) SC Or Bural Roy ARY LA ar as stated due to the eavailable due to	cause of death 4 Onknov utopsy findings a prior to ion of cause? 2 No cene	
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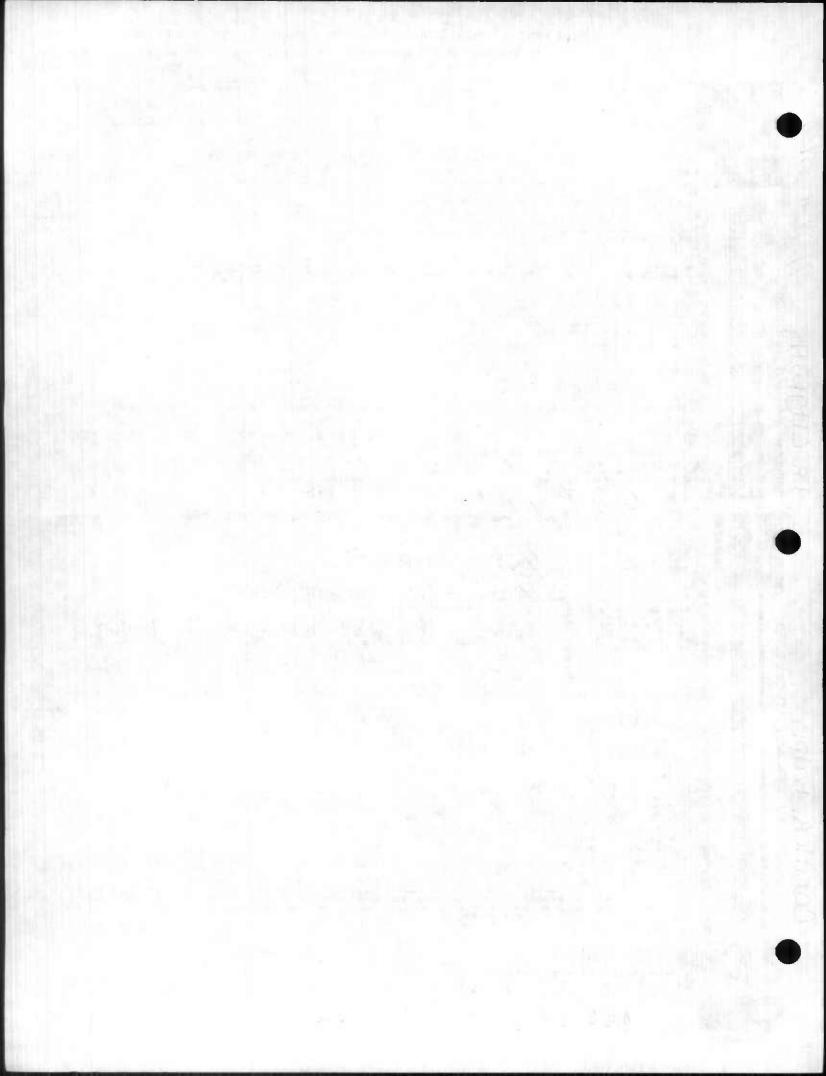
State of Maryland / Department of Health and Mental Hygiene 00 25050

	Certificate of Death	Reg. No.											
	Decedent's Nama (First, Middle, Last)	Date of Death Month Day Year 3. Time of Death											
sician edical	Gertrude J. Combs	July 31, 2000 23:25											
er	4e Facility Name (If not Institution, give street and number) 4b. City, Town	n, or Location of Death 4c. County of Death											
	Union Hospital of Cecil County Elkton	Cecil											
	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24	4 Hrs. 8. Date of Birth Min. (Month, Day, Year) 9. Birthplaca (State or Foreign Country)											
r	214-20-4796 1 M 2NF 76 Yrs. Months Deys Rours	April 16,1924 Tennessee											
•	Usual Rasidenca of Decedent												
0	10a. Stata 10b. County 10c. City, Town or Location	10d. Inside City Limits											
Director	Maryland Cecil North East	1 ☐ Yes 2 💢 No											
Sire	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?											
Funeral [23 Nazarene Church Road 21901	United States											
2 e	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Original In Yas, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc.											
	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No I ☐ Yes 2 ☒ No Specify:	Specify:											
ò	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	White											
e e	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. Do NOT use retired)	of working											
d	Elementery/Secondery (0-12) College (1-4or 5+)												
To Be	11 Homemaker	In her own home											
	17. Fathar's Nama (First, Middla, Last) 18. Mother	s Nama (First, Middle, Maiden Sumame)											
	Charles A. Humphrey Mammi	Le Church											
	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code)											
	Amos Combs / Spouse P.O. Box 371, North East, Maryland 2190												
* 5	20a. Method of Disposition 20b. Place of Disposition (Nama of Computer Comp												
	1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) August 4.												
	North East Methodist Cemetery 2000 North East, Maryland 21. Signature Funeral Service-Licensee 22. Nama and Address of Facility												
	Crouch Funeral Home, 127 South Main Street,												
	North East, Mary	yland 21901											
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cashock, or heart tailure. List only one cause on each line.	ardiac or respiretory errest, Approximate Interval Between Onset end Death											
		7											
	Immediate Cause (Final disease or condition TYDOWL ASCHOMIC)	ncephalopaly 3 days											
	resulting in death) Due to (or as a consequenca of):												
Examiner	- Hente Keenhuter	4 Janlure 3days-											
carr	Sequentially list conditions, Due to (or es a consequence of):												
	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury cause)	allopas 15 years											
edical	that initiated events rasulting in death) Last Dua to (or as a consequence of):	exprox.											
any	d	1											
Sici	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t.	23b. Did tobacco use contribute to the cause of death?											
Physician/M	The hatte - M. O. Il.	1 Yes 2 No 3 Probably 4 Unknown											
by P	Janey 10 Meet 17hm -												
		24a. Was an autopsy performed? 24b. Were eutopsy findings avaitable prior to											
let		performed? available prior to completion of cause of death?											
certificate has been s rector, page 2 should b Be Completed		1 Yes 2 10											
Be	examiner? Hospitel: Other:	of Death (Check only one)											
T0	1 Inpatiant 2 EH/Outpatient 3 DOA 4 Nurs	sing Home 5 Residence 6 Othar (Specify)											
Certification:	27. Menne√of Death 1 ☑Netural 5 ☑ Pending 28a. Date of thjury (Month, Day Year) 28b. Time of Unitry at Work?	28d. Describe how injury occurred											
cat	2 Accident investigation M 1 Yes 2 N 3 Suicida 6 Could not be												
=	4 Homicide determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, State)											
	building, etc. (specify)												
edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
Σ	29b. Signature end title of certifier 29d. Date signed (Month, Day, Year)												
	Springents leli (VU101) \$122301 8/1/00												
	30 Name and address of person who completed cause ol/death (Item 23a) (Type Print)	1 1 6 1											
	SATANTILAI K HATEL 1238In	serly He ZI(cton, MI)											
•	31. Date filed (Month, Day, Year) 32. Registrar's Signatura												
tate	ALIC O O 2000												



State of Maryland / Department of Health and Mental Hygiene 00

	450			Oldic Ol	TVICITY ICITY		tificate of	Death		Reg. No.	JU	260	60
	Physician	1. Decedent's Name (Fit							2. Date of De Month	-	Year	3. Tima of	
	/Medical	RALPH :							July	31, 20	0000	9:30	PM
	Examiner	4a Facility Name (If not						4b. City, Town, or			nty of Death		
5		Harford	-				W11-44 V	HAvre o			ford		
9	Funeral Director	5. Social Security Number 196-18-66 Usual Residence of Dec	58 ×	ex 7	. Age (In yrs. I	Yrs.	Months Days			rth ay, Year) 1923		nplace (State ountry) nsylv	
9	iand was		. County		10c. City	, Town or Loc	ation		-1-13			10d. Inside C	ity Limits
0	the Mary 28a-f sh notified a	MD	Ceci1			Port	Deposi	lt				1 🗆 Yes	2/2N0
25	or 28a-f s be notified Director	10e. Street and Number			7	77.11	10f. Zip Code			10g. Citizen of	f What Co	untry?	
10		8 Orc	hard I	rive			2190)4	9.00	USA			
-0020	urs after death val. or heme 23 Examiner must by Funeral	11. Maritel Status 1 Never Married 3 Widowed 4	XXMerried	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Yeer or Dat	NK6			Hispanic Origin? (Spen, Mexican, Puer	Specify Yes or No to Rican, etc.)	В	ace - Amer lack, White Whit		
9-0	12 ho	15.	Decedent's Ed	ucation		16e. Deced	ent's Usual Occu	pation during most of wo	rkina	Business/I	Industry		
27	ed within 72 ho ygiene. wr than "naturn 4, the Medical. Completed	Elementery/Seconder	nly highest grady (0-12)	College (1~	for 5+)	life. D	O NOT use retire	iduring most of wo	rking				
75	on the	12				Fire	Fighte						ce
3 Ro	Mental Hy integrated offi- affic event	17. Father's Neme (First George	, Middle, Last) Cant	ler				18. Mother's Name (First, Middle, Maiden Sumeme) Emma Smith					
- Wan	and 2 sho ath and 1 27 is me or fraums	Shirley J. Cantler- wife 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, 2 8 Orchard Drive, Port Deposit, MD											
A. F	Pages 1.	20a. Method of Disposition TOTAL Place of Disposition (Name of cemetery, crematory or other place) A Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Nebo Cemetery 8/4/2000 Delta, PA											
Balti	Departs Departs Imports any inju	21. Signature of Funeral Service Licensee Harkins F.H. Inc., 600 Main St Delta 1 17314											A
		23a. Parti Entre the dis	seese, or come	dicetions that car	used the deeth	. Do not ente	r the mode of dv	Ing. such as cardia	c or respiratory	arrest.	1	/314 Approxima	te
68760,	Compared to the compared to th	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or Injurthat Initiated events resulting in death) Last		. Isula b. Chara c. Repn	Due to (or	as a consequence as a c	Pulmon vence ot):		ense			stomy	
Box	at the death cert d by the attendin elected for use Physician/N			d							1		
o.	the a	Part II. Other significant	conditions co	entributing to dea	th but not resu	iting in the un	derlying cause g	iven in Part I.	23b. Dld	tobacco use o	ontribute	to the cause	of death'
9.		Hunons	16106						10	Yes 2 No	3 P	robably 40	Unknow
C 10	1 68 5	11/00/01	71-10						-11.00		1	with the second	
45	med med participants	Colomin	M m	ABOUT 1	DISOMAR				24a. Wa: perl	s an autopsy ormed?	6	Were autopsy evellable prior completion of	to
Culph Records,	law sesb sess nple	Chen 1	1 - 1	1010	1					/	1	of death?	04.030
	ician: The lay certificate has nector, page 2 Be Comp	Mineral	SLEAPUR	MA	/				1 🗆	Yes 20 No		1 ☐ Yes 2 ☐] No
Vital	Ba stor.	25. Was case referred to	medical	-					ath (Check only	one)			
50	To To	1 Vag 2500			patient 2 1	ER/Outpatient	3LI DON		dome 5 ☐ Res	idence 6 🗆 C	ther (Spe	city)	
	ball or Attending P is sher death. at Director: After the ad in by the funera Certification:	27. Menner of Death 1 Natural 5 [Pending	28a. Date of (Month)	Injury Dey Year)	28b. Time of Injury	28c. Inju		28d. Describe	how injury occ	urred		
Division	the the	2 Accident 3 Suicide 6	Investigation Could not be					Yes 2 No					
- E	or All Bleed Lin by	4 Homicide	determined	208. FIECE C	f Injury - At ho g, etc. <i>(Specify</i>	me, tarm, stre)	et, tactory, office		28f. Location City or To	(Street and Nur wn, Stete)	nber or Ru	iral Route Nur	nber,
50			/										
9	n 24 hours n 24 hours ne Funeral pletsity fille edical C	(Check only 2		Iner: On the bas	is of examinati			ime, date and piace opinion, death occ					s)
)	# s # d 6	one) end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Data signed (N											
	5 1 5 8	290. Signature and title	or certifier				29C. Licen	/ / / h	,	4/	O O	n, Day, Year)	
	(1)	r 117W	7111		4,	1 150	1/4	041		011	0		
	10	Name and address of	1 3	9 5.	Unlo	NA	Print)	de n	10	21.78			
	State Registrar	AUG	_	- 100	gistrer's Signat	G.	Sport	w	-Vol.	, , ,			



26061 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death July 31, ^{Day} 2000 Eleanore Loretta Cardiff 11:20 PM 4a. Facility Nama (if not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Brooke Grove Assisted Living Olney Montgomery 8. Date of Birth (Month, Day, Ye Jan. 23, li Undar 1 Year li Under 24 Hrs. Months Days Hours Min. Year) 9. Birthplaca (State or Foraign Country)
Pennsylvania 8. Sax 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F Yrs 87 10c. City, Town or Location 10d. Insida City Limits

Funeral Director

Physician

/Medical

Examiner

5. Social Security Number

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hyglena. Int: If them 27 is marked other than "natural", or thems 23a or 28e-f ahow and Hygiene and a natural, or items 23s or 28s-f show event, the Medical Examiner must be notified at permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760. signed by the at Id be detached for peed has certificate this Aftar aftar death. in by the Director:

the Hospital or Attending Physician: The law requires that the death certificate be asscuted within 24 hours aft To the Funeral Di completely filled in

Immediata Causa (Final MYOCARDIAL disease or condition resulting in death) CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or es e consequence of): Physician/Medical Dua to (or as a consequence of): Part it. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part t. 1 Yea 2 No 3 Probably 4 Unknown þ Completed 25. Was case refarred to medical 8 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Raeldence 6 Other (Specify) 2 1 Yes 2 No 28c. Injury at Work? 27. Mannar oi Death 28a. Data of injury (Month, Day Year) Certification: 26b. Tima oi 1 Naturel 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 26a. Placa of Injury - At homa, ferm, streat, factory, offica building, atc. (Specify) 4 Homicida Certifying Physician: To the bast of my knowledge, daeth occurred at the time, dete and piece, and due to the ceuse(s) and mannar as stated.

Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and mannar stated. 29a, Certifian Medical 29b. Signatura and titla oi certifing 29c. Licansa number 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 7542 (ED E. HOWE

211-26-6078 Usual Residence of Decedent 10a State 10b. County Maryland Montgomery Rockville 1 ☐ Yas 2 X No Director 10e. Street end Number 10f. Zip Coda 10g, Citizen of What Country? 5 Osprey Court 20855 USA Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-il Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indien, Black, Whita, atc. 11. Meritel Stetus 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Completed by Specify: White 3536Vidowad 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elemantery/Secondery (0-12) Collega (1-4or 5+) Registered Nurse Nursing 17. Fether's Nema (First, Middle, Last) 16. Mother'a Nama (First, Middla, Maldan Sumama) Be Bartly Flannery Mary Malia 2 19a. tnformant's Name/Reletionship (Type, Print) (caughter) Mrs. Geralyn C. Praskievicz 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 5 Osprey Court Rockville, MD 20855 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramovel irom Steta 8/5/00 Shenandoah Hieghts, PA 4 ☐ Donation 5 ☐ Othar (Specify) Annunciation Cemetery 21. Signeture of Funaral Service Licenses 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications/that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arraet, shock, or heer leiture. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximate Intarval Between Onset and Death 30 MINUTES

23b. Did tobacco use contribute to the cause of death?

24b. Wara sutopsy findings available prior to complation of causa of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Deta algned (Month, Day, Year)

SOONSBORD, MD

AUGUST 2000

31. Dete filed (Month, Day, Yaar) State Registrar

AUG 3 2000

OVERLOOK DR 32. Registrer's Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dele of Deeth Month 1 Year **Physician** Jessie W. Dade 1800 31 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner George's Hospital Cater Chevely Prince George's 8. Deta of Birth (Month, Day,) Sep. 4, If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 938 Days Hours Months 1 M 2 XF Wash., D.C. 578-52-1155 61 Director **Usual Residence of Decedent** the Mandend 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits r then "natural", or items 23s or 28s-f show the ideologic Examples must be notified at 1 Yes 2 No Director Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 ahould be filed within 72 hours after death with Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 28s or any Injury or other traumstic event, the second of the pages. 1905 Billings Avenue 20743 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married **Black** Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Professional Government 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) 8 Armstead Wells Martha Lunsford 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon White - Daughter 3110 Rose Valley Dr., Ft. Wash., MD 20744 20b. Place of Disposition (Nama of cametary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 8/5/2000 Landover, MD 22. Name end Address of Fecility 21 Signature of Funeral Service Licen-Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 or the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, the filter. List only one cause on each line. Approximete Intervel Between Onset end Daath **Physician** Hemo rrhage /Medical tmmediate Cause (Finel disease or condition resulting in death) Examiner Examiner physicien end s the buriel-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): 8 987 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Onknown à should I 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes en autopsy parformed? Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No Mospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this carifled intely filled in by the funeral director; Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1☑Inpatient 2☐ ER/Outpatient 3☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Titedical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. 29a, Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chevely Manyland 20785 Wester 304 Hospital Drive 31. Date filed (Month, Day, 32 Registrar's Signature AUG 0 4 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Mary E. Donoghue 2000 3:44 P.M. Ju₁y /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7115 Lory Lane Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min 10 M 20 F 168 26 5731 Yrs. 67 Director 30,1932 Pennsylvania Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show X₩Yes 2 No Prince George's Maryland Director Lanham r than "natural", or hams 23s or 28s-f the Medical Examinar must be notifi-10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 7115 Lory Lane 20706 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 茶營No if Yes, Give Yeer or Detes: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes XX No Specify: Specify: White Àq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental ant: If flow 27 is merked o Gerald Marrs Helen Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Edward I. Donoghue Husband 7115 Lory Lane Lanham Maryland 20706 20b. Piaca of Disposition (Name of cemetery, cremetery or other place) August 4, Date 2000 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery Cheltenham Maryland 4 ☐ Donalion 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. M01095 16000 Annapolis Rd. Bowie Maryland 20715 caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, sech line. Approximete Interval Between Onset and Death **Physician** ancer, metastatio Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medicai Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) P.O. Box 68760, that initieted events resulting in death) Last Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yee 2 No Division of Vital Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has page 2 X No 1 Yes 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 1 Yes 2 No 10 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 28d. Describe how injury occurred Certification: 28b. Time of Injury at Work? After 5 Pending investigation Injury Director: Aff 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a To the Funeral C Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated. edicai 29a. Certifier completely To the 29b. Sign 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and use of deeth (Item 23a) (Type Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

AUG 0 2 2000

32. Registrar's Signature

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im	plicio Do	omigpe		State of M	laryland		artment of		nd Mental Hy	giene	0 21	5064	
	Physiciar		nt's Name (First, Middle,	Simplicio	D. De	omi one	s. Sr.		2. Date of De			Time of Death 10:21 am	
	/Medica Examine	4a Facility	Name (If not institution, g					Forre	m, or Location of Death st Heights	4c. County			
	Funeral Director	577-	ecurity Number 6 98–9859 dence of Decedent	Sex 7. A	ge (In yrs. las	st birthday) Yrs.	ff Under 1 Yes Months Day		4 Hrs. 8. Date of Bir (Month, Da May 25	th ly. Year) ,1925	9. Birthplaca Country) Philipp	(State or Foreign	
	and show and show alled at	10a. State Maryla	10b. County and Prince (George's		Town or Lo						nside City Limits Yes 2 No	
	th with the Ma 23s or 28e-f s unit be notified		and Number ree Dr.				10f. Zip Code 207			10g. Citizen of V USA			
020	72 hours after death with the Maryla natural, or litems 23a or 28a-f sho lifed Examiner must be notified at seed ho. E. mared Director	3 □ Wid	Status ver Married 2 X Married dowed 4 □ Divorced	Armed Forces	1 ☐ Yes ②XNo If Yes, Give 1 ☐ Yes 2 ☑ N				in? (Specify Yes or No Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Asian/Filip		
20	72 ho natur dical		15. Decedent's (Specify only highest)		ucation 16a. Dece			cupation ne during most ired)	of working	16b. Kind of Bu	usiness/Industr	y	
Maryland 21215-0020	led within 72 ho typiene. her then "neturn it, the Medical.	Element	ary/Secondary (0-12) 10th	College (1-4or	5+)		oo NOT use reti ien Atte	endant			Food Se	rvice	
and	The fi	5	s Name (First, Middle, La						's Name <i>(First, Middle</i> Cisca Dura		10)		
Mary	od 2 should lith and Meni	19a. Inform	Isidro Domigpe, Sr. 19a. Informant's Name/Relationship (Type, Print) Nellie Millando/Daughter				-	et and Number	er, City or Town,		6)		
Baltimore,	Pages 1 ar nant of Heam ant: if Heam 2 ary or other	1 X Bu	20e. Method of Disposition 1 Disposition 1 Date 20c. Location - City or cemetery, crematory or other place) Resurrection Cemetery 7/31/2000 Clinton, Md										
Balt	Departi Departi Importi any Inj 2008	1	22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 The Part Enter the disease, or complications that cannot the death. Do not enter the mode of dying, such as cardiac or respiretory errest, interval Between Interval Between										
	Physician /Medical Examiner	Immediate disease or resulting in	Cause (Finel condition	mpications that can be in a cause of the cau	Due to (or e	ONO	ging	nying, such as c	ardiac or respiretory e	rrest,	Inte	oroximata rival Between set and Death	
x 68760,	leath certificate be assocuted attending physician and for use as the burial-transit clan filled for the particular for the par	Cause (Dis	lly list conditions, fing to immediate ter Underlying sease or injury of events in death) Last	c	Due to (or a								
P.O. Box	uires that the death certific is signed by the attending p id be detached for use as id by Dhyeldian/Mex	Part II. Oth	er significant conditions	but not resulti	ing in the u	nderlying cause	given in Part I.		23b. Did tobacco use contribute to the c				
Records,	aw requires the bean signed 2 should be done by the body								24a. Was	an autopsy ormed?	availab	autopsy findings le prior to ation of cause h?	
	certificate rector, pag	OF Was as								Yes 2□No	1000	s 2 No	
\geq	Physicien: this certific ral director,		ase reterred to medical er? s 2 No	Hospitel:	ient 2 EF	R/Outpatier	at 3 DOA	0.1	of Deeth (Check only sing Home 5 ☐ Resi		ner (Specify)	at scene	
Division of Vital	Attending Physician: The I strategy. stdeath. ector: After this certificate ha by the funeral director, page liffication: To Be Com		r of Death tural 5 Pending cident investigat	28e. Dete of Inj (Month, D		8b. Time of	28c. fr		28d. Describe	how injury occur		relf	
Divis	is after or led in Carr	27. Menner of Death Natural Natural Suicide Accident Suicide All Homicide Suicide Su									The o	20745	
	thin 24 hours thin 24 hours the Fune impletely fil	(Check one)			of examination				I plece, end due to the h occurred at the time,				
	To the Complete of the Complet	296. Signal	ore and title of certifier	Cun				ense number	0.0	29d. Date signe	d (Month, Day,		
	(5)	30. Name a	and address of person wh	o completed cause of	death (Item 2		Print)		, Baltimor				
		100	MACIO CO	CLE (ON)		1.	rr term	pricer	, but thint	c, mary	.diki 214	701	

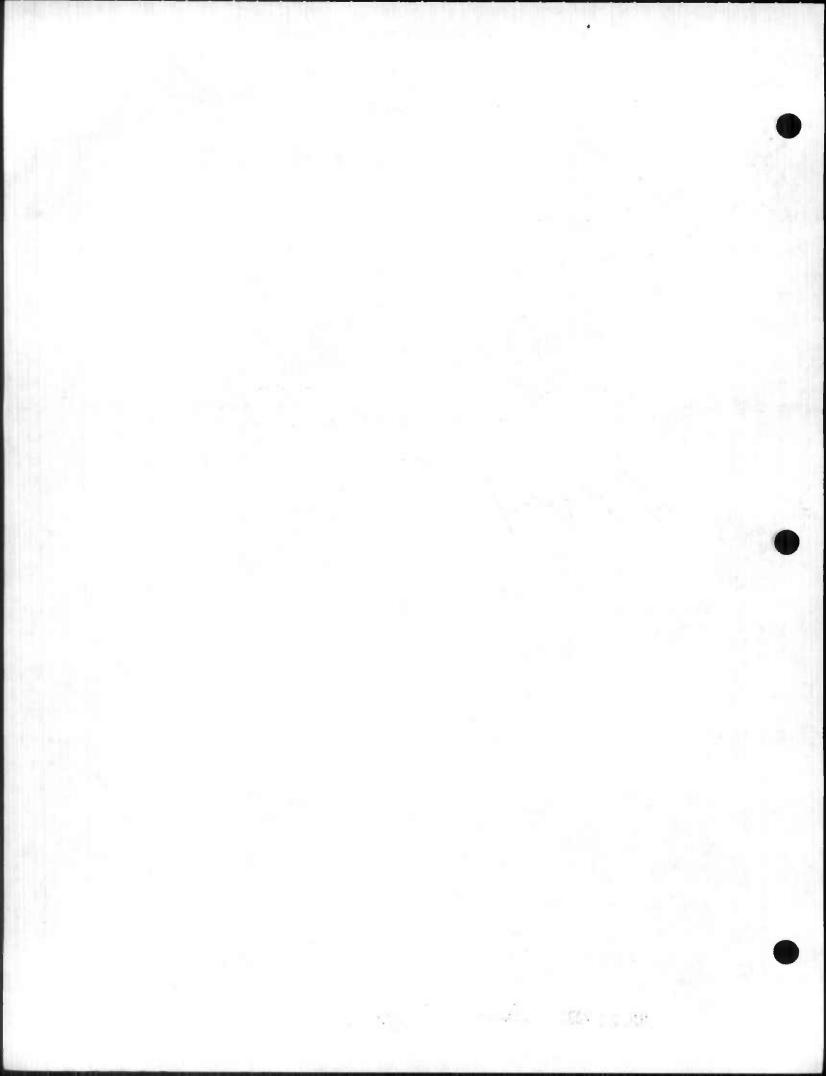
State Registrar 31. Date filed (Month, Day, Year)

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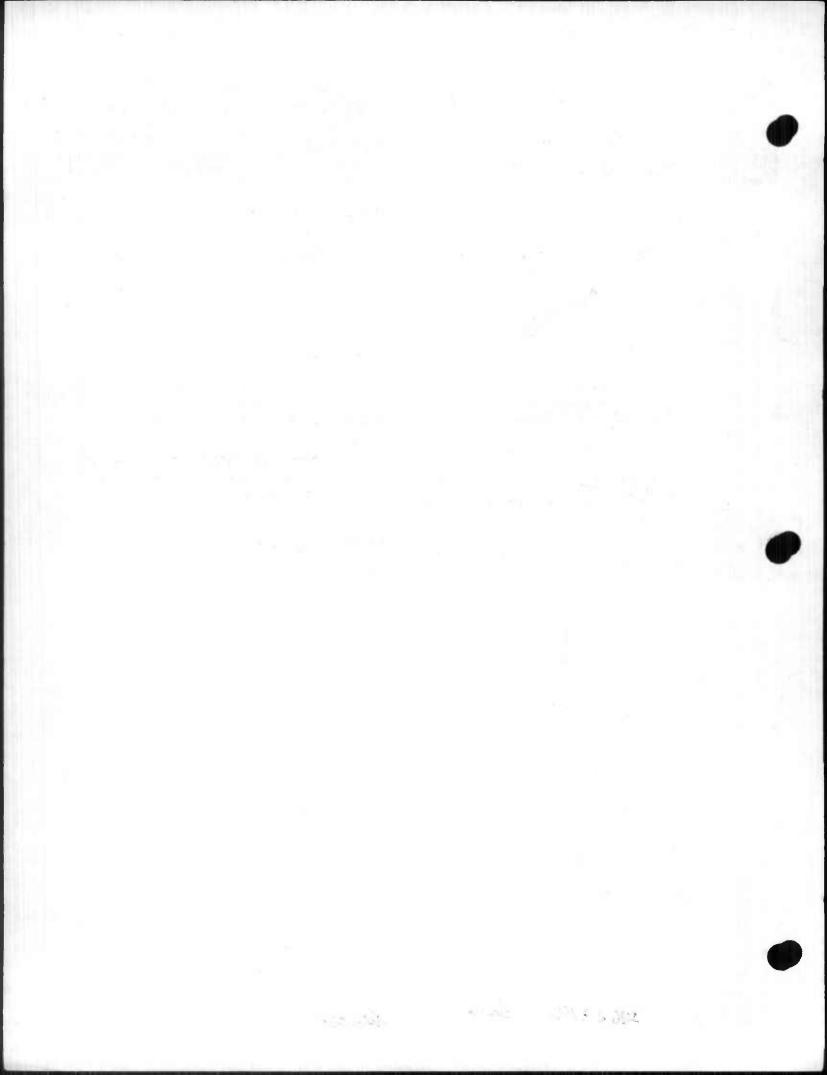
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32. Registrar's Signature

Spark



	Decedant's Name (First, Middle, Last)	or Death	Reg 2. Date of Death	j. No.	3.	Time of Death
Physician /Medical	ODELLA DORSEY		Month	30	2000 J	7:20 Aus
Examiner	a. Facility Name (If not institution, give street and number) MAKUNER HEALTH OF BETHET DA	4b. City, Town, or Lo		4c. County	of Death	ALY.
uneral rector	as at 04-3203 10 m 24 1 + L Vrs.	Yeer If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y		9. Birthplace (State or Goleign Country)	
23a or 28a-f show ust be notified at ral Director	Suel Residence of Decedent Oe. State 10b. County 10c. City, Town or Location SOVTH EAST	WASHINGTON	ND.(.			side City Limits Yes 2□No
be notified Director	0e. Street and Number 10f. Zip C	ode	10g		Whet Country?	
eted by Funeral		20032 nt of Hispenic Origin? (Sper Cuban, Mexican, Puerto ZNo Specify:		14. Rac	d States - American Incok, White, etc. Africa Americ	dien,
event, tre Medical is Be Completed	Elemantary/Secondary (0-12) College (1-4or 5+)	Occupation done during most of work retired) Sewife	ing 16		usiness/Industry	
_	7. Fether's Name (First, Middle, Last) Joe Ponder		(First, Middle, Ma	iden Sumam		
To	9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (-	Straat and Number or Run		City or Town,	State, Zip Code)
other treumatic event, I	On Mothod of Disposition (Name	St., Alexar			City or Town, S	***
ry or o	1 MBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) A Removal from State Harmony Memori	er place)	/4/2000		over, MI	
any injury or c	21. Signature of Funeral Service Licenses 22. Name and		Stewart F	uneral	Home	
the buriet transit and leading the second se	mmediate Cause (Final liseasa or condition southing in death) a. Due to (or as a consequence of): dequantially list conditions, any, leading to immediate ause. Enter Undarfying causa (Disaase or injury causa (Disaase or	G CANCER				
edic edic	nat initiated events soulting in death) Last Due to (or as a consequence of): d.					
d by Physician/M	art II. Other significant conditions contributing to deeth but not resulting in the underlying cau — HYDERTENSION WITH STROKE	se givan în Part I.		2 No	ntribute to the c	
eted	- PRESSURE SORES,		24a. Was an a performe		available	on of ceuse
Comp	- CONGESTIVE HEART FAILURE		1 ☐ Yes	2 No	1 ☐ Yas	V
orector O Be	5. Was casa referred to medical examiner? 1		n <i>(Check only one)</i> me 5□ Residenc	e 6 □Oth	ar (Specify)	7.1
a funeral di ntion: To	7. Mannar of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 4 Injury 4 Month, Day Year) 4 Injury 5 M	. Injury at / Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	Injury occurr	red	
led in by the funera Certification:	3 Suicide 4 Homicida 6 Could not be datarmined 28a. Place of Injury - At home, farm, street, factory, of building, atc. (Specify)	office	28f. Location (Stree City or Town, S		er or Rural Rout	'e Number,
Completely filled in by the fune Medical Certification	9a. Cartifier (Check only one) Cartifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and menner stated.	the tima, data and place, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and ma and place,	inner as stated. and due to tha c	ausa(s)
Comp	L. Shyamsundar D	10053367	29d.	Date signed 7/3	d (Month, Day, 1	(ear)
1	D. Name and address of parson who complated cause of death (Item 23a) (Type, Print) 10810, DARNES TOWN ROAD, SVITE: 202,	GAITHERS	BURG, 1	MD:	20878.	
State	1. Date filed (Month, Day, Year) 32. Registrar's Signature					



State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate of	Death	Re	g. No.	26066				
	1. Decedent's Name (First, Middle, La	ist)				2. Date of Death	1	3. Time of Deeth				
Physician /Medica	(=) adve	May	Dou	glas		JULY 29		11:30A.M				
Examine	A - F NA - Al	re street end number)			4b. City, Town, or Lo	cation of Death	4c. County of					
	CIVISTA MEDICA	L CENTER		400	LA PLAT	A	CH	ARLES				
Funeral	Social Security Number 6. S		rs. last birthday)	If Under 1 Year Months Days		8. Dete of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country)				
Director	01. 11 0010	1□M 2√F 9	7 Yrs.			Sept. 5	1902	Maryland				
pu *	Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Loc	ation				10d. Inside City Limits				
darys f aho				otte Ha	11			1 ☐ Yas 2 No				
vith the Ma	Maryland St. Mar	ys	Clari	10f. Zip Code	<u> </u>	10	g. Citizen of Wh	et Country?				
deeth with the Maryland ms 23s or 28s-f show croust be notified at		eek Drive			622		U.S.A					
Ciffer deeth v	11. Marital Status	12. Was Decedent Ever in	U,S. 13. W		Hispanic Origin? (Spotan, Mexican, Puerto	ecify Yes or No-		- American Indien,				
o the read of the		Armed Forces? 1 Yes 22 No If Yes, Give Year or Detes:		Yes, specify Cul		Rican, etc.)	Specify:	White, etc. White				
121215-002 ed within 72 hours by then "naturel", it, the Medical Ex-	15. Decedent's Ed (Specify only highest gra		16a. Decede	ent's Usual Occu	pation during most of work	ina 1	6b. Kind of Busi	ness/Industry				
A A = E	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retin	9d)							
	8th	N/A	Ho	memaker			Han					
Maryland 212 Maryland 212 Rahould be filed with h and Mentel Hygiens. I te marked other that reumstic event, that	17. Father's Neme (First, Middle, Last)				18. Mother's Name							
aryian should be nd Mentel merked ametic ev		Tawney			Lilliar							
Man Man	19a. Informant's Neme/Reletionship (et end Number or Run								
Baltimore, Maryland 2 permit. Pages 1 and 2 should be illed Department of Heelth and Mentel thy important: if them 27 is marked other any injury or other treumatic event, page.	Arthur H. Doug		n) 378] . Place of Dispos	0 India	n Creek Di			Hall, MD 20622 ity or Town, State				
Pages nent of the lay or o	1 XBurial 2 ☐ Cremation 3 ☐	Removel from State	edar Hil	story or other pla								
F. P.	4 Donation 5 Other (Specif	"				8/3/00 Suitland, Marylander Funeral Home Inc.						
Baltimore, Baltimore, permit. Pages 1- Department of Hes imporant: if Nem any Injury or othe adds.	1 5£ 9.5	21. Signature of Funeral Service Licumous 22. Name end Address of Facility Lee Funeral Home, In 6633 Old Alexandria Ferry Road Clir										
P.O. Box 68760, let the death certificate be assecuted by the attending physicien and seached for use as the burist-transit	Cause (Disease or injury that initiated events resulting in death) Last	Due to	Cor as a consequence of the cons	LERO- ence of):	ART F	AILUR ART D	WEAL	Onset and Deeth				
O e de d	Part II. Other significant conditions of	ontributing to death but not re	esulting in the un	derlying cause g	iven in Part t.	23b. Dld tot	acco uss cont	ributs to the cause of death?				
P.O. het the de by the deteched	SERSIS					1 ☐ Ye	2 2 No :	Probably 4 Unknown				
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death carly the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician A.	SEPSIS	A				24a. Wes an		24b. Were autopsy findings available prior to completion of cause of death?				
He le	Be had been seen					1□ Yes	2 No	1 Yes 2 NA				
/Ital	25. Wes case referred to medical				26. Place of Death			10.100 20.110				
of VI hysician his central direction To B	examiner?	Hospitel: 1 Inpatient 2	☐ ER/Outpatient	3 DOA O	ther	me 5 Resider		(Specify)				
ifon of ading Physics After this funeral attorn: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)		28c. Inju		28d. Describe how	_					
DIVIS DIVIS Rater de la Directo ed in by the Contific	3 Suicide 6 Could not be determined		home, ferm, stre	et, factory, office		28f. Location (Str. City or Town,		or Rurel Route Number,				
Division c the Hospital or Attending P thin 24 hours after death. the Funeral Director: After Impletaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of rrly kr niner: On the basis of examir and manner steted.	ime, date and place, a opinion, deeth occurr	and due to the car ed et the time, da	use(s) and mani te and place, an	ner as stated. d due to the cause(s)						
To T	29b. Signature and title of certifier	mand	la	29c. Licen	se number	29		(Month, Dey, Year)				
	P V, Jnw	0		D-2	6064		1-3	0-2000				
(2)	30. Name and address of person who	completed cause of deeth (Ite	em 23a) (Type, P	rint)								
	VIDYASAGAR ANN 31. Date filed (Month, Day, Year)		D. P.O	. BOX	282 CHAR	LOTTE I	IALL MI	20622				
State Registrar	ALIG 0 1 2000	37 Registrar's Sign	B.	books								

. 100 0 1 2000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Tobias Leon Davis 8, 2000 6:35am Aug. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata Charles If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 1 MM 2□ F 40 08-12-1959 Ohio Director 567-37-6929 Usual Residence of Deceden should be filled within 72 hours after deeth with the Maryram nd Mental Hyglena. marked other than "satural", or frems 23a or 28e-f show umatte event, the Medical Eventher man be notified. 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1102 Fairbanks Court 20602 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, atc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yas 2 ☐ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marketing Director Financial Company 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked oths eny injury or other treumatic event, phose. 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Castor Lania Arthur Noble Davis, Jr. 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1102 Fairbanks Court, Waldorf, Maryland20602 Mary Elizabeth Davis/Wife 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata DeBurial 2 ☐ Cremation 3 ☐ Removal from State August 15, 2000 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 21. Signature of Funeral Service Light 22. Name and Addrass of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Maryland or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, List only one cause on each line. 23a. Part1. Enter the dis-shock, or heart failu Approximate Interval Batween Onset and Death Physician Immediata Cause (Finat disease or condition resulting in death) /Medical COLON CAYCER Examiner Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? pega 2 certificata has 1 ☐ Yas 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) To 1 Yes 20 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1-2 Natural 26b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun. 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and due to the cause(s) and manner stated. edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28352 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Data filed (Month, Day, Year) 32. Flagistraghi Signatura AUG 0 9 2000 >

Krishan M. Mathur, M.D.

3500 Old Washington Rd. Waldorf, MD 20602

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Baitlmore,

68760

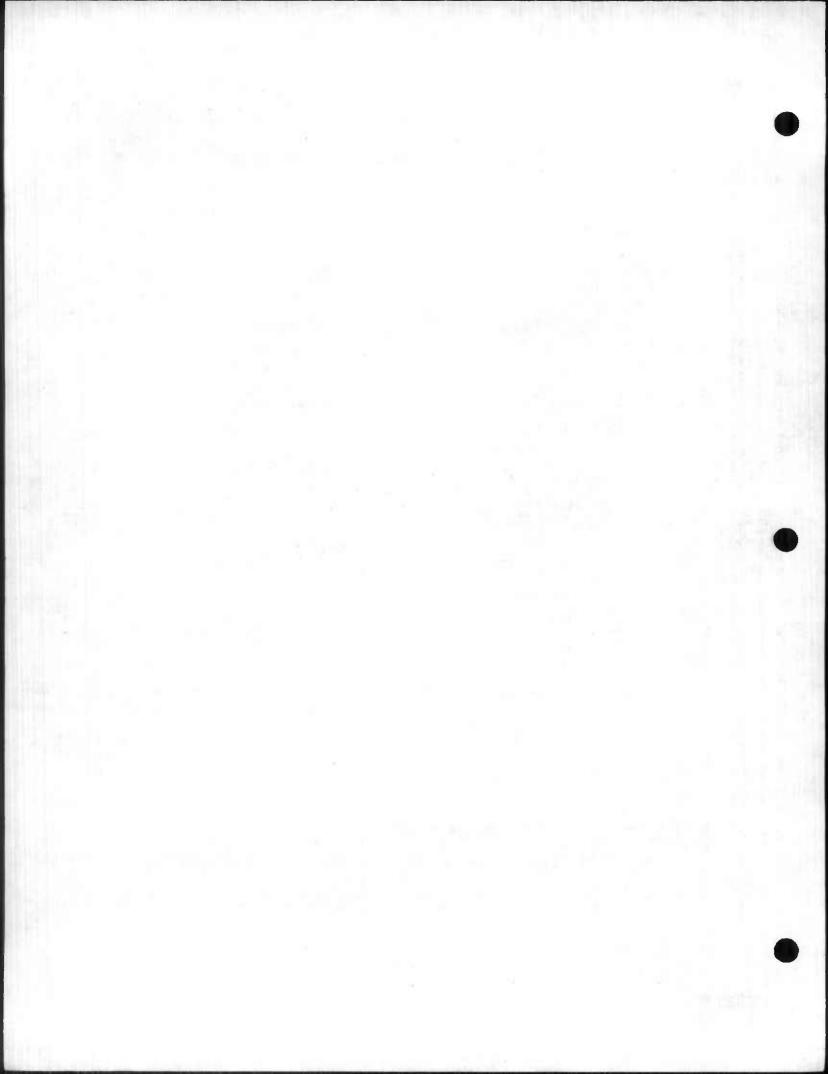
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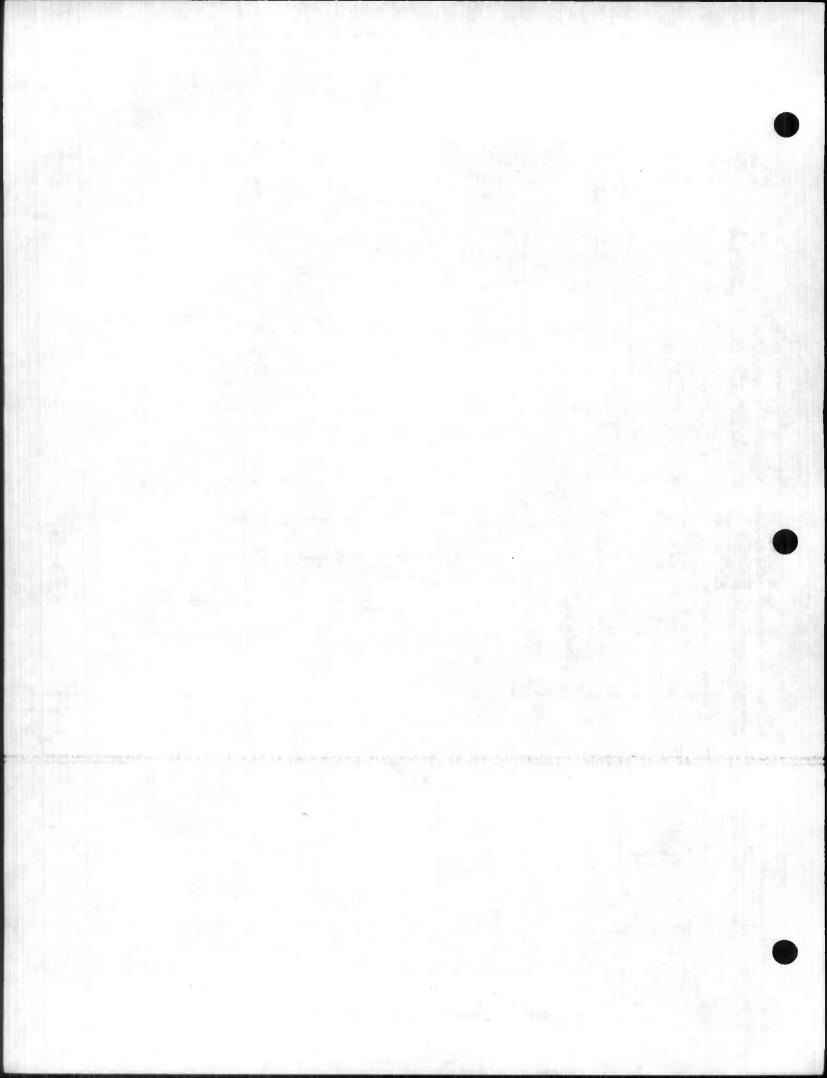


State of Maryland / Department of Health and Mental Hygiene

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		Ce	rtificate d	of Death		Re	g. No.		-0000	
1. Decedent's Neme (First, Middle, La	nst)					Date of Deet	h Dev	Year	3. Time of Death	
Mildred Lee DEAN							6, 2000		3:30 a.m	n.
4e Facility Neme (If not institution, given	ve street and number)		West to the	4b. City, To	wn, or Locatio		4c. County			
Western Maryland	Hospital C	enter		Hage	erstown	n	Wasl	hingt	on	
5. Sociel Security Number 6. 9 230-30-7894		n yrs. last birthdey Yrs.	Months De		Min.	Dete of Birth Month, Dey, ay 16,			lece (Stete or Foreig try) ginia	giri
Usual Residence of Decedent 10a. Stete 10b. County	10	oc. City, Town or L.	ocation					1	Od. Inside City Limit	ts
		, o. o.,, rom. o. e		Orm					1⊠ Yes 2□N	
Maryland Washi	ngton		Hagerst			14	Da. Citizen of V	What Caus	10.2	
1500 Pennsylvani	la Avenue		101. Zip Cox		742			SA	ary r	
11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 Tes 2 No If Yes, Give Year or Detes:	r in U,S. 13.	Wes Decedent If Yes, specify (1 ☐ Yes 2 ☒			Yes or No- n, etc.)		e - Americ k, White, Whi	etc.	
15. Decedent's E (Specify only highest gri		(Give	dent's Usual Oc	ne durina mosi	t of working		16b. Kind of Bu	usiness/Inc	dustry	
Elementary/Secondery (0-12)	College (1-4or 5+)		DO NOT use re				waa kauwan k			
11	0	10	od prepa				4:4-0		taurant	
17. Father's Neme (First, Middle, Last unknown	0				a Bess		Maiden Sumer mick	18)		
19e. Informent's Neme/Reletionship	(Type, Print)		ing Address (St							
Wilma L. Brill - daughter 7736 Pleasant View, Middletown, Va. 22 20e. Method of Disposition (Name of cemetery, cremetory or other place) 20b. Pleas of Disposition (Name of cemetery, cremetory or other place)										
20e. Method of Disposition 1 ☑ Buriet 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		Co., Va.								
21. Signeture of Funeral Service Lice	HOM	E 21740								
Immediate Cause (Finet disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. — Due	sclerotic e lo (or es a conse e lo (or es a conse e to (or es e conse	equence of):	ovascula	ar Dise	èase			Minutes	
Pert II. Other significant conditions of	contributing to death but n	ot resulting in the	underlying cause	given in Pert I	1.	23b. Did to	bacco uss co	ntributs to	the causs of deati	h?
Hypertension						t 🗆 Y	88 2□ No	3 Pro	bably 4∑ Unkno	wn
Quadriplegia						24a. Wes en autopsy performed?			era autopsy findings allable prior to mpletion of cause deeth?	\$
E-III WALL NO						1 🗆 Ye	s 2X No	1[Yes 2□ No	
25. Was case referred to medical				26. Place	e of Deeth (CI	neck only on	e)			
exeminer? 1⊠ Yes 2 No	Hospitel: 1 Inpatient	2 ER/Outpetie	ent 3 DOA	Other			nca 6 □Oth	er (Specif	y)	
27. Menner of Death	28a. Dete of Injury (Month, Dey Yo			Injury at Work?			w injury occur			
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3 Suicide 6 Could not be determined	ice		City or Town	n, Stete)		Al Route Number, hester, VA	١.			
27. Menner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 28a. Dete of Injury 3-30-75 28b. Time of Injury at Work? 1 Yes 2 No fall down concre which down in the determined state of the properties of the pro								enner as s	tated.	
29b. Signeture end title of certifier). Dito:			cense number			9d. Dete signe August			
30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Edward W. Ditto, III, M.D., 19011 Orchard Terrace Rd., Hagerstown, Md. 2174									742	
										-

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

							of Death			Reg. No.		
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Physician /Medical	Richar	d S	Snavelu		Dutfi	1		F	vaust		2000	0015
Examiner	4a Facility Name (If not	institution, giv	a street and numbe	1		7	4b. City, To	wn, or Loca	tion of Desti	h 4c. County	of Death	
	Washington	Count	y Hospita	al				agers			ngton	County
uneral	5. Social Security Number			-	last birthday)	If Under 1 Ye Months Da		24 Hrs. 8	Date of Bir (Month, Da	th Year) 1917	9. Birthpla	oce (State or Fore
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t or 28a-f show be notflied at Director	Usual Residence of Dec			10c City	v. Town or Lo	cetion					10	d. Inside City Lim
											1 X Yas 2 □	
	Maryland Washington Co. Hagerstown									77 1112		
Dir.	10e. Street and Number					10f. Zip Cod	10			10g. Citizen of	What Countr	y7
23.	1111Sunnyside Drive 21742								Yes or No- 14. Race - American Indian,			
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and be					16s Deced	lant's Usual Oc	cupation			16b. Kind of B	usiness/Indu	istry
olete	(Specify or	15. Decedent's Education (Specify only highest grade completed)			16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)							,
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edical	Immediata Causa (Final						dying, such as	cerdiac or i	respiratory a	irrest,		Approximate Interval Between Onset and Daath
edical iminer	Immediata Causa (Final disease or condition resulting in death)		a. A.	Due to (o	// ~ O∧ a ~ or as a conseq	uance of):	holus				1	Interval Between Onset and Daath
	disease or condition resulting in death)		a. A.	Due to (o	n as a conseq	uance of):					1	Interval Between Onset and Daath
	disease or condition resulting in death)		a A	Due to (o	or as a consequence of as a consequence of as a consequence of as a consequence of a conseq	uance of):	spireto-	70	yene		10	Acys
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NAME: **DUFFY,RICHARD SNAVELY** DOS: **07/18/2000** 12/16/1917 82 / M RIGGLE,KARL P.

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State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Deta of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death Month **Physician** CARRIE C. DOW 2000 JULY 26 9:55 am * /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS NURSING & REHAB. CENTER ANNAPOLIS ANNE ARUNDEL 7. Age (In yrs. last birthdey) If Under 1 Yeer | If Under 24 Hrs. | 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 M 255 Yrs. 220-16-8887 106 APRIL 26 1894 MARYLAND Director Usual Residence of Decedent the Maryland 10h County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinating the notified at 1 Yes 2X No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death 962 OLD ANNAPOLIS NECK ROAD 21403 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours aftar I Department of Health and Mental Hygiene. Important: if item 27 ia marked other than "natural", or iten any injury or other traumatic event, its Mad call Exattrant 1 Navar Married 2 Married Specify: BLACK Maryland 21215-0020 1 Yes 2 XNo If Yes, Give Yaar or Dates: Specify py 3 Widowad 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) CAPITAL RESTAURANT COOK 6th 0 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nema (First, Middle, Last) Be UNOBTAINABLE ROSIE WILLIAM BROOKS 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 2 1 4 0 3 19a. Informant's Name/Relationship (Type, Print) 1243 CROWS NEST CT. ANNAPOLIS, MD. SARAH A. HAMMOND (GRANDAUGHTER) Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State BREWER HILL CEMETERY 8/1/00 ANNAPOLIS, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licansae 10 6 983 22. Nama and Address of Fecility
WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 Larry 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediete Ceusa (Finel diseese or condition resulting in death) /Medical Examiner Examiner **buriel-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): and physician Box 68760 Physician/Medical the Due to (or es e consequence of) 9 attanding Por ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? P.O. 1□ Yes 22 No 3 Probably 4 Unknown signed t Division of Vital Records. by 24b. Were autopsy findings available prior to 24e. Was en eutopsy Completed peen completion of cause of death? certificata 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury at Work? After 1 Naturel
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: A completaly filled in by the fu investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. edical 29a. Certifier Signature and title of continer 29c. Licansa number 29d. Data signed (Month, Dev. Year) and address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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600 RIDGEDAL in 32. Registrar's Signature

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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Year **Physiclan** James Clifford Dew August 2000 7:30 AM /Medical 4b. City, Town, or Location of Deeth 4a. Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Talbot Hospice House Talbot. Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. lest birthdey) 5. Social Security Number Birthplace (Stete or Foreign Country) **Funeral** Months Deys 1 € M 2 □ F Yrs. 213-22-5056 Director January 31, 1928 Delaware Usuel Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if terms 23a or 28a-1 show important: if terms 21 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinatorial to notified at 10d. Inside City Limits 1 TYes 2 □ No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28515 Oakmont Drive 21601 United States 12. Was Decedent Ever In U.S. Armed Forces? 1946 1 1 2 Yes 2 □ No 1947 If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2√ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11 HS Grad. Owner/operator Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Raymond Charles Dew Pauline Thawley 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 28515 Oakmont Drive, Easton, Maryland 21601 Dorothy M. Dew 20a. Method of Disposition 20b. Plece of Disposition (Name of cometery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removel from Stete 4 ☐ Donstion 5 ☐ Other (Specify) 8/3/2000 Dover, Delaware Capitol Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 100re 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Cancer. disease or condition resulting In death) Examiner Due to (or as a consequence of) Examiner physician end the burief-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequenca of) for use es signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ should b 24b. Were autopsy findings evailable prior to completion of cause 24a. Was an eutopsy performed? Completed of death? has 1□ Yes 2□No 1 TYAS 2 No Division of Vital 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 PAesidence 6 Other (Specify) 1 Yes 2 No funeral 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Time of After 5 Pending investigation 1 Neturel death. 1 Yes 2 No To the Hospital or Attendition within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as steted.

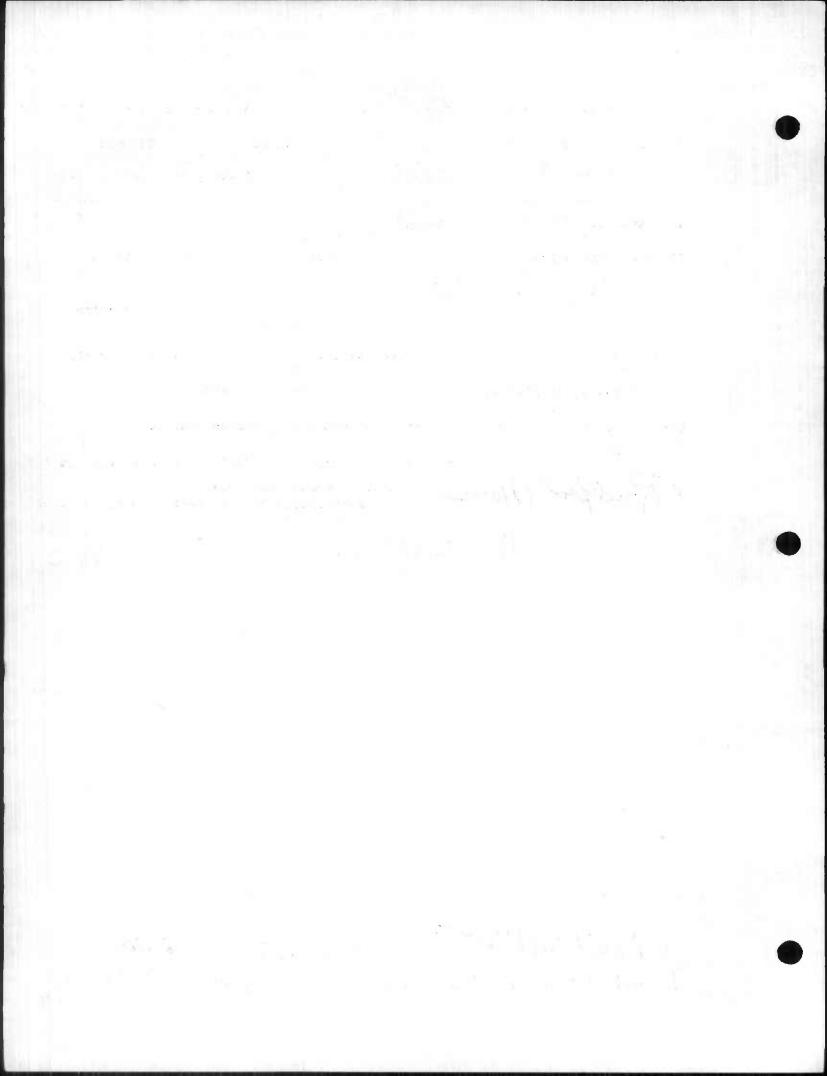
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) and manner steted. edical 29a. Certifier 29b. Signative and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30 Name pleted cause of death (Item 23a) (Type, Print) Pintail Drive, Suite \$ Easton, mo -2946le 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State - 4 2000

Please Type or Print In Black indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar **DHMH 16 Rev 6/95**

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 00:15 Henry S. Darlington, III 2 , 2000 4c. County of Death 2 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Elkton Cecil 116 Park Towne Drive If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (fn yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** Days Hours 1XM 2□ F Yrs. 194-32-3137 58 Director NOV 19, 1941 Pennsyl.vania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limita 10a. Sfete 10b. County r than "natural", or flams 23a or 28a-f show the Medical Exampler must be notified at 1 X Yes 2 □ No Directo Maryland Cecil Elkton 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21921 United States 116 Park Towne Drive Funeral death 14. Race - American Indian, Black, White, etc. 12. Wes Decedenf Ever in U,S. Armed Forces? 13. Waa Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Stetus filed within 72 hours after 1 XYes 2 No M Yes, Give Vietnam Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Quality Assurance Manager Tool and Die Shop 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Sara Moore Henry S. Darlington, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Department of Health a Important: If Item 27 Is any Injury or other tra-Rose M. Gatta Darlington/Wife 116 Park Towne Drive, Elkton, Maryland 21921 20b. Pleca of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Hockessin, 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Delaware Hockessin Crematory 8/5/00 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 Jonaed S 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dylng, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Lung Cancer Examiner Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): The law requires that the death certificete be execu Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. detached á 1 Yes 2 No 3 Probably 4 Unknown ate has been signed page 2 should be de Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed' After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Thomicide within 24 hours a To the Funeral C Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as steted.

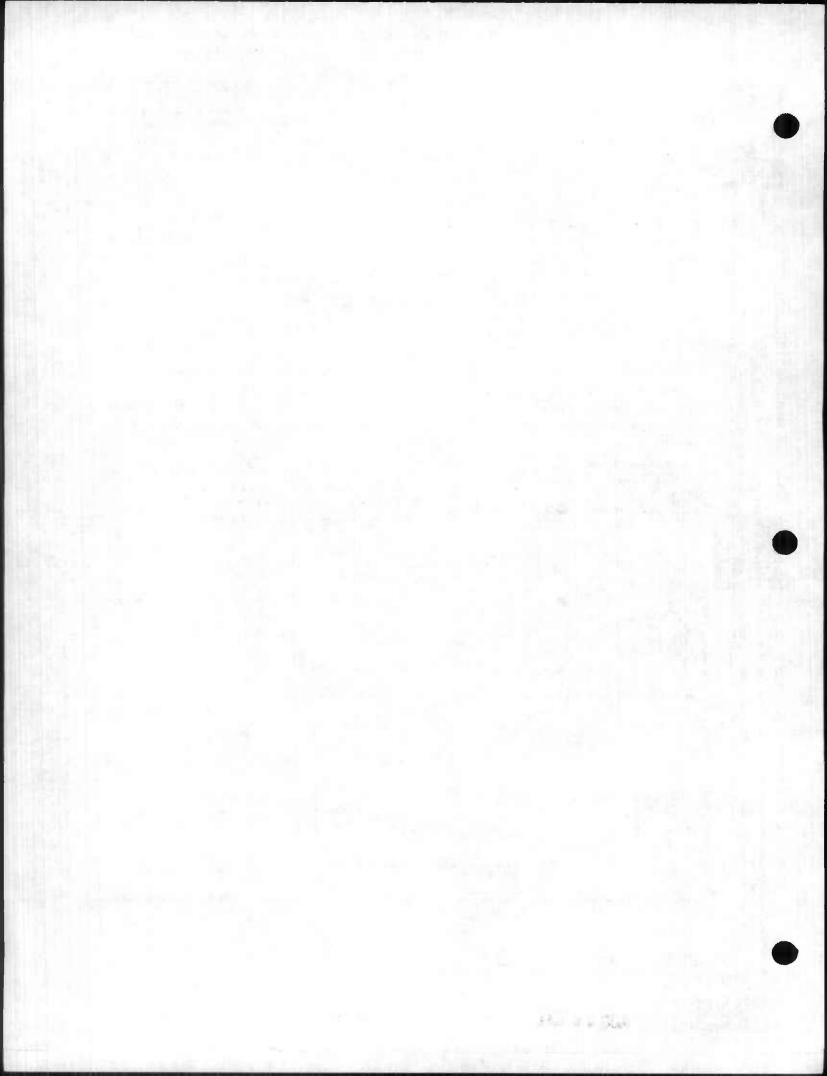
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2 +1VA Chesapenhe Hospice, & 1kton ar Kas INA Nortem 31 Date filed (Month, Dey, Year) 32. Registrar's Signature State

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State of Maryland / Department of Health and Mental Hygiene [] [] amend item 8 per fh G787 9/21/00 yf Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Daath Month **Physician** Virginia Gladvs Duncan 0958A July 7000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Bel Air Bel Air Harford 8. Date of Birth Sept. Month, Day, Year Aug. 3, 1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 20 F Months 86 031-18-2224 Director Mass. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stata 10b. County 10d Inside City Limits must be notified at 1 ☐ Yes 2 ☑ No Director Montgomery Gaithersburg 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 22521 Sweetleaf Lane 20882 U.S.A. Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 223No If Yes, Give Year or Dates: Herns 2 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 7 is marked other than "natural", or item traumatic event, the Magical Examiner. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2000 Specify: Specify: White 20 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) School Teacher Education 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hi ant: If item 27 te marked oth Be Hilbert Nelson Emma Pearson 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) Peter Hartwell (Nephew) 22521 Sweetleaf Ln., Gaithersburg, MD 20882 other 20b. Place of Disposition (Name of camatery, crematory or other placa) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co., Inc. 8/2/00 West Chester, PA ture of Funeral Service Licensee 22. Nama and Addrass of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Approximete Interval Betwean Onset and Death **Physician** Cerebrorusulan /Medical Immediate Cause (Final YIAVS disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting In deeth) Lest Due to (or es a consequence of): Physician/Medical # Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by d be defact 1 Yee 25 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to complation of causa of death? 24a. Was an autopsy Completed 1 Yes 20 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Varsing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA alui. 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral Di compleisity filled in 29a. Certifier 1 Cartifying Phyelcian: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Neme and address of person whp completed cause of death (Item 23e) (Type, Print) Oil fir Mary land HOSWILL Arenus 32. Registrar's Signeture 31. Date filed (Month, Day, Year) 2000 Registrar

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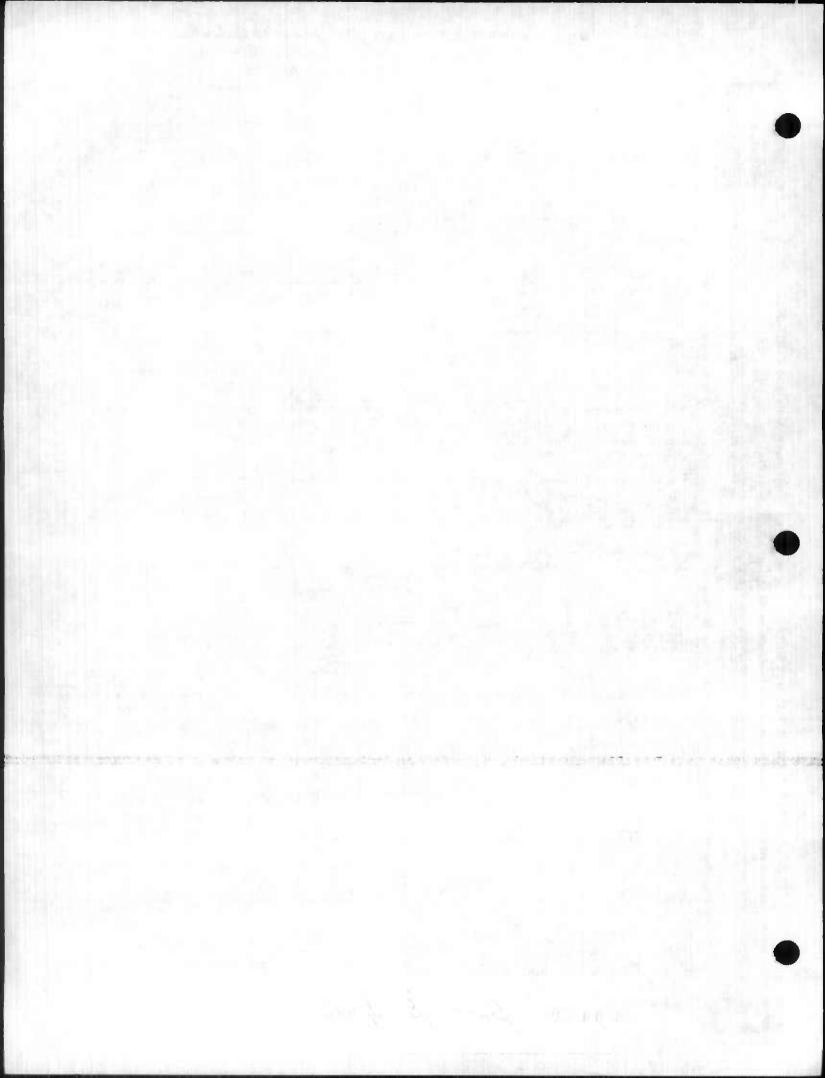
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State of Maryland / Department of Health and Mental Hygiene 00 26074

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Medical aminer	4a Facility Name (If not institution Washington Cour						wn, or Location	of Death	4c. County Washi		
eral ctor	5. Sociel Security Number 219-20-2047	6. Sex 123 M 2□ F		. last birthday) Yrs.	tf Under 1 Yea Months Day	r If Under	24 Hrs. 8. Da	ale of Birth conth, Day, Ye	uar)	9. Birthple Count	ace (State or Foreign ry) yland
by Funeral Director	Usual Realdence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					10	d. Inside City Limits
Director		ngton		Hager							1 ☐ Yes 2X No
	10e. Street and Number 57 S. Colonial	Drive			10f. Zip Code	2174	.0	10g.	Citizen of V USA	Vhat Count	try?
Funeral	11. Maritel Status 1 □ Never Married 2⊠ Merri	12. Wes Dec	2 No		Was Decedent of if Yes, specify Cu 1 ☐ Yes 2 ☒ No	Hispenic Ori ban, Mexicer	gin? (Specify Y	es or No- etc.)	14. Race	e - America k, White, e	etc.
(q p	3 Widowed 4 Divorced	Year or I		11				100		Wni	
Completed by	15. Decedent (Specify only highes Elementery/Secondery (0-12)	grade completed) (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use retii	e durina mos	t of working	100	. Kind of Bu		
Cod	8	0		fire	truck d	_	d. N /5'				dept.
To Be	17. Fether's Name (First, Middle, I Albert M. Elgir		418					Le Wood	ls		
	19a. Informant's Name/Relationsh Loreda V. Elgir				ng Address (Stree S. Colon						
	20a. Method of Disposition 1 Buriai 2 Cremation 4 Donation 5 Other (Sp.	3 ☐ Removel from	State	Place of Dispo cemetery, crer	esition (Name of metory or other power Ceme	(ace)	Dat 8-5-(e 200	Location -	City or To	
	21. Signature of Foreral Service I			22	Name and Add	ress of Facilit	MINN	CH FUN	IERAL	HOME	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieled events resulting in death) Last	b. Ch	Due to (or as a consection or as a conse	tive Pul quence of): sis		Diseas	se .			Onset and Death
	Part II. Other significant condition	0					l. 2	23b. Did tobe	cco use co	ntribute to	the cause of death
y Physician	Diabetes Melli	tis						1 Yes	2 No	3 Prob	ebly 4 🖾 Unknow
Completed by	Right Upper Lo	bectomy	for Lun	ng Canc	er		2	4a. Was an a performed	utopsy 1?	ava	ore autopsy findings ailable prior to appletion of cause death?
Com			1 - 21					1 🗆 Yes	2 🔯 No	10	Yes 2 No
o Be	25. Was case referred to medical examiner?	Hospitel:			-5	Wher	of Death (Che				
\vdash	1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending investig	28a. Date (Mo	Inpatient 2 of Injury nth, Day Year)	28b. Time o Injury	28c. In	jury at fork?		Sescribe how			0
Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be ned 28e. Plea	e of Injury - At I ding, etc. (Spec	nome, farm, str	eet, factory, offic	8		ocation (Streetity or Town, S		er or Rura	l Route Number,
edical C	29e. Certifier 1 Certifying (Check only one) 1 Medicat 8	Physician: To the ixaminer: On the l	e best of my kn basis of examin nner steted.	owledge, deetl etion end/or in	n occurred at the vestigation, in my	time, dete an opinion, dea	d place, and duth occurred at 1	ue to the caus the time, date	e(s) and ma end place,	anner es st end due to	ated. the cause(s)
Me	29b. Signature and title of certifier	See.				nse number 52323		29d.	Date signe 8/2/0		Day, Year)
	30. Name and address of person of Khacid Waseem					lke, Ha	agersto	wn, Md	2174	2	
State gistrar	31. Date filed (Month, Day, Year) AUG 0 4 2	32.	Pégistrer's Sign	,	Spork						

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician HAROLD July FLOWERS, JR. 31 2000 1535 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** t M 2□ F Months Days Hours Min. Yrs 27 Director 578 90 7042 October 6,1972 Washington DC Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Rem 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event. In Medical 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2415 59th Avenue 20785 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Disabled N/A 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Harold Flowers Rosa M. Jordan 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Harold Flowers, Sr./father 2415 59th Avenue Cheverly, MD 20785 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 8-7 Landover, Maryland 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 21. Signatur of Funeral Service Licenses - 10000 4308 Suitland Road Suitland, MD 23a. Pal 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician end the burial-transit requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): 88 use 10 signed by the a 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes No 3 Probably 4 Unknown Division of Vital Records, p 24b. Were autopsy findings available prior to should I Completed 24a. Wes an autopsy performed? completion of cause of deeth? s certificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes or Attending Physician: director 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 npatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menper of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After Injury Natural 5 Pending efter deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 4 Homicide filled in 24 hours e Funeral D Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai completely (Check only one) within 2 the th 29d. Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier

3 State

31. Date filed (Month, Dey, Year) AUG 0 3 2000

James Catavenis, MD 3001 Hospital Drive 32 Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

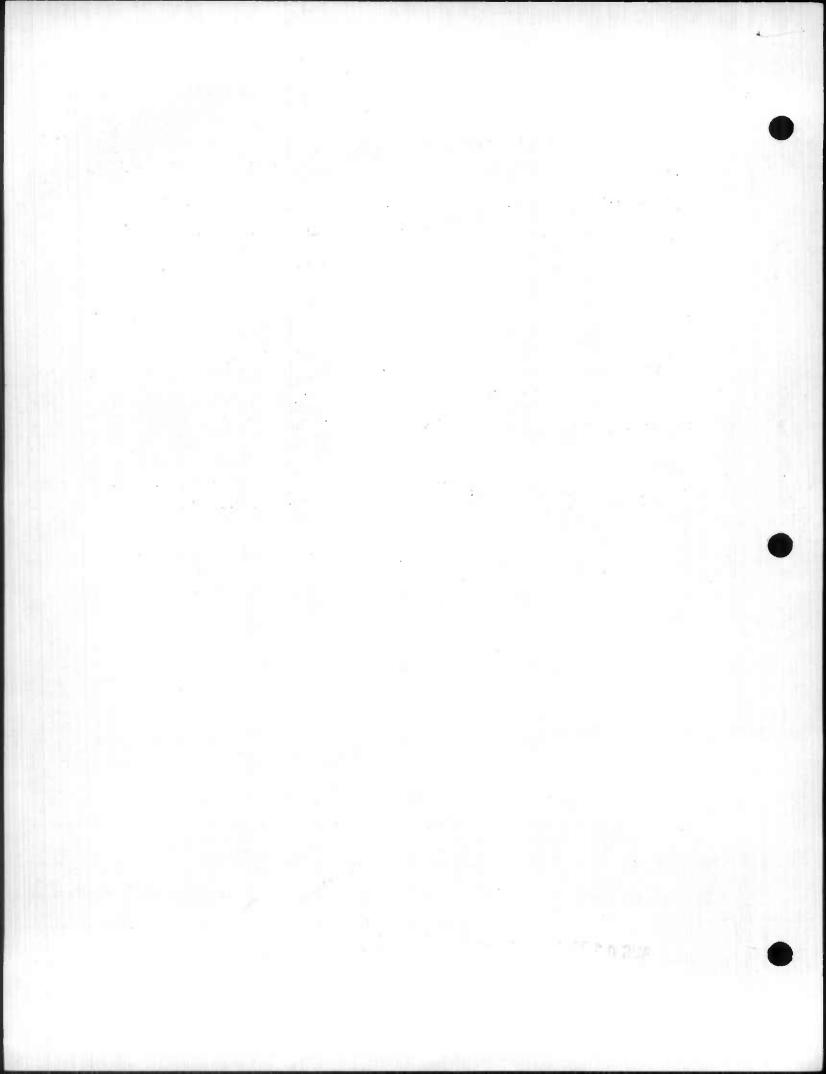
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James E. Vann Funeral 4804 Ga. Ave. N. W. Wash. D. C. 20011 23. PART I. Enter the diseases, or configurations that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest. IMMEDIATE CAUSE (Final disease or condition and interest or condition and interest or condition and interest or condition and interest or conditions. BUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQ	4 Donetion 5 Oth	er (Specify)									Was	shingto	on, I	O.C.
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	NOTED TO SET IN Notice 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ditions, nediate YING niury AST TO MEDICAL Pending investigation Could not b determined ERTIFYING PH	B. Liet only one can B. DUE TO B. DUE TO C. DUE TO d. One contributing to MOSPITAL: 1 Inpatient 2 28e. DATE Of (Month.) 10 28e. PLACE of building	O (OR AS A COM O (OR	NSEOUENCE (NSEOUE	OF): OF): OF): OF): OF): In the ut Null ME OF NJURY M , street, fac	nderlyin 26. Ph: raing Hon 28c. IN. 1 □	e end placed death occur	given in f	Part I. Cok only one So Other 286. LOCA City of	24e. WRS AN PERFOR	I AUTOPSY RMED? 2 M NO INJURY OCCU end Number or	24b. W AA A	Approxima Interval Be Onset and Interval Be
Dr. Goldstein 9410 Old Georgetown Rd. Bethesda, Md.	NOTE CAUSE (Figure 1) A Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting to immediate cause. Enter UNDERL CAUSE (Disease or in that Initiated events resulting in death) PART II. Other signification of the condition of the cond	ititions, nediate. YING plury AST cent condition of the period of the p	B. Liet only one can B. DUE TO B. DUE TO C. DUE TO d. One contributing to MOSPITAL: 1 Inpatient 2 28a. DATE Of (Month, in the best of the basis of the bas	D (OR AS A COM D (OR	INSECUENCE (INSEC	OF):	nderlyin 26. P R: maing Hon 28c. IN. W 1 1 ttory, office	ILACE OF (CONTROL OF CONTROL OF C	given in a	Part I. Cok only one So Other 286. LOCA City of	24e. WRS AN PERFOR	I AUTOPSY RMED? 2 M NO INJURY OCCU end Number or	24b. W AA A	Approxin Interval E Onset an Interval E Onset



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** August 1625 1-01+Z Vora Lee 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Washington County Hospital Hagerstown WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) July 1, 19 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 216-80-2824 79 Yrs. Virginia Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director MD Washington Hagerstown 10a. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 8 501 Claire Street or Items 23a 21740 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Reca - American Indian, Bleck, Whita, atc. 11. Marital Status 1 Yes 2 No If Yas, Give Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p "natural". White Completed 15. Decedent's Education (Specify only highast grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) Housewife 5 Home 0 other 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 1 and 2 should be leeith end Mentel le marked Edgar Lee Hensley Rosalie 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Reletionship (Type, Print) permit. Peges 1 and 2. Department of Heelth elimportant: if item 27 leany or other tree Ray E. Foltz 17510 Virginia Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State Cedar Lawn Memorial Park August 8, 2000 Hagerstown, MD 21740 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Europa Servi 22. Name and Address of Facility P.O.Box # 348 Williamsport, MD 21795 Approximata Intarvat Between Onset and Deeth in disease, or complicetions that ceused the daath. Do not antar the mode of dying, such es cardiac or respiratory arrast, at failure. List only one cause on each line. **Physician** Immediate Cause (Finel disaase or condition resulting in death) /Medical reck Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last attending physician Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy performed? Completed After this certificate has 2 1 No 1 ☐ Yas 2 ☐ No 1 Yes Vital 25. Was case referred to examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas , 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA of 28e. Date of Injury (Month, Dey Year) 27. Menney of Death Injury at Work? 28d. Dascribe how injury occurred Certification: Division Hospital or Attanding 1 DNatural 5 Pending Invastigation Injury after deeth. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicida To the Hospital within 24 hours a To the Funeral D edical 29a. Cartifier 1 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. 29d. Date signed/(Month, Dey, Year) 29c. License number 29b. Signatura and titla of certifian 30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print) 11/10

State Registrar

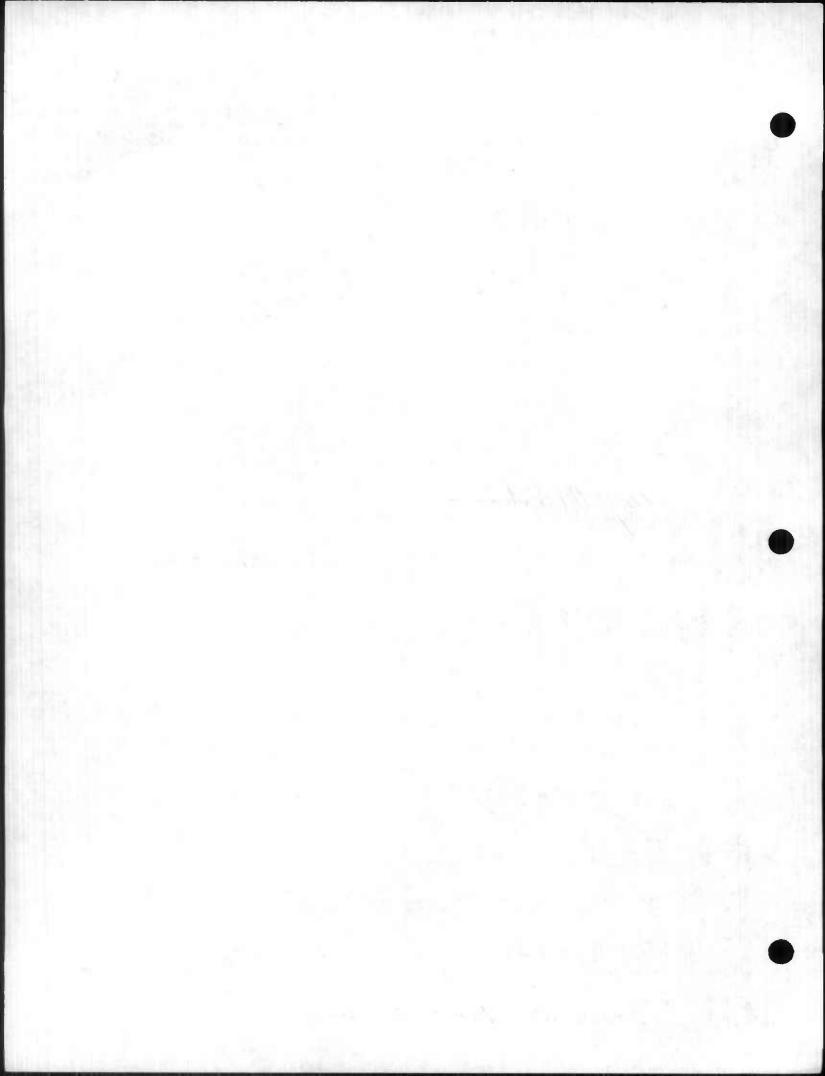
31. Date filed (Month, Dey, Year)

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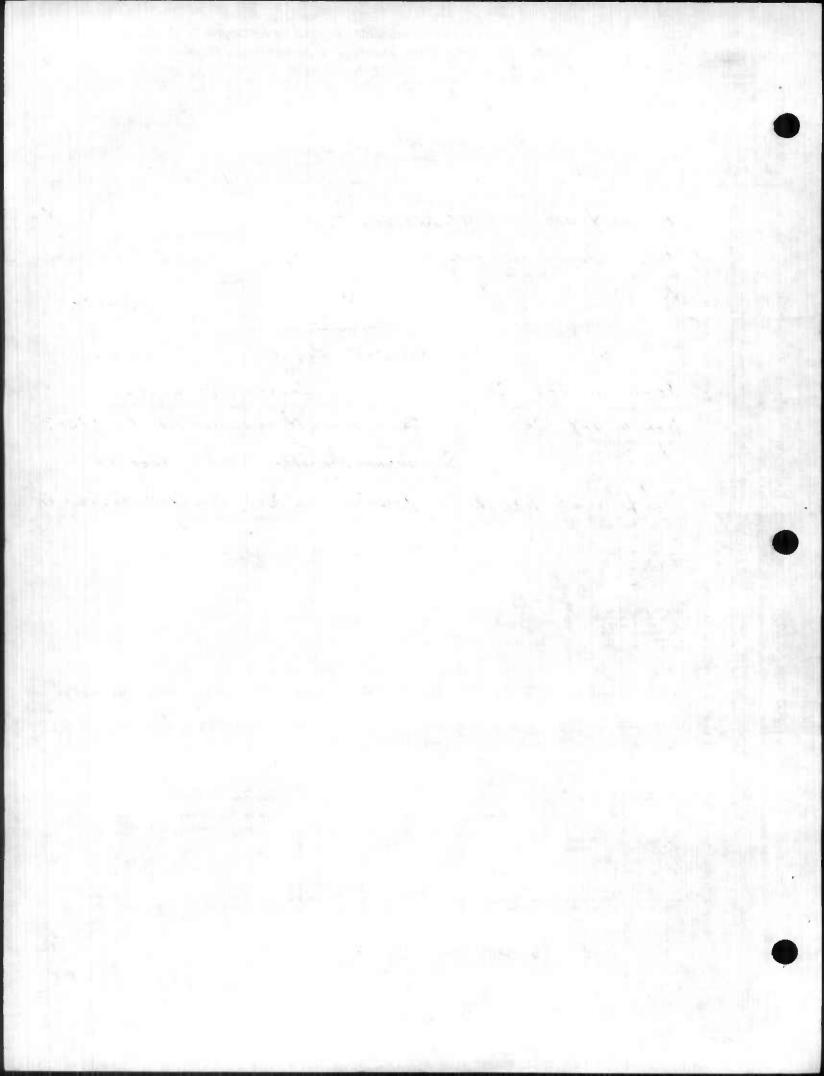
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32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 00 26078

amend ite	m 9,29c per fh,dvr G786	8/16/00 yg		ite of Death		leg. No.	20010
Physician /Medical	1. Decedent's Name (First, Middle, Last)	Fry			2. Date of Dea Month	Dev	Year 20:30
Examiner	4a Facility Name (If not institution, give s		dical Sy	1 Sten Balki	Location of Deeth	4c. County o	/ Death
Funeral Director	5. Social Security Number 6. Sex 19166206.7	M 200 7. Age (In y/s.	last birthday) If Und Yrs. Month	ler 1 Year If Under 24 Hrs s Days Hours Min		2/1970	9. Birthplaca (State or Foreign Country) York, PA
M Wand	10e. State 10b. County	10c. Ci	ty, Town or Location		10.16	7.75	10d. Inside City Limits
s Mar	PA YORK	C	YANCE FORG	TWP			1 ☐ Yes 2 No
th with the Mar 23e or 28e-f et at be notified al Director	10e. Street and Number	0,1 2,1	10f. 2	Zip Code		10g. Citizen of Wi	
fler death v r flems 23s siner must funeral	12853 HAMPER	2 Was Decedent Ever in I	90 E I.S. 13. Was Dec	17309 edent of Hispanic Origin? (Specify Yes or No-	4. S	- American Indian,
urs after of Franches Examines by Fun	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		pedent of Hispanic Origin? (Specify Cuban, Mexican, Pue	rto Rican, etc.)	Specify:	White, etc. WHITE
of within 72 hours al ygiene, we than 'natural', or it, the Medical Exam Completed by I	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Us (Give kind of	vork done during most of wo	orking	16b. Kind of Bus	Iness/Industry
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be filed tal Hygies d other event, it	17. Father's Name (First, Middle, Last)		770073777		me (First, Middle,		
Mental Me	JOHN M FR	y SR		SAND.	RA H	ELTZE	2
2 sho	19a. Informant's Name/Reletionship (Typ	e, Print)	19b. Mailing Addre	ss (Street and Number or F	-		1
Haadi Haadi Sheet 1	20a. Method of Disposition		Pleca of Disposition (A		DALLAS		Pa 173/3 City or Town, State
Pages ment of ant: If th jury or o	1 Burial 2 Cremation 3 BRe 4 Donation 5 Other (Specify)	moval from State	cametery, crematory of		7/25/20		e, Pn
Demil Depart Import any in	21. Signature of Funeral Service Licanse	Laugher	Austra H.	end Address of Facility Excly F. M. 10	4 W. Moin	UST DA	Unstown, Pa
	23a. Part1. Enter the disease, or complice shock, or heart failure. Listonly one	ations that clused the dea	th. Do not enter the m	ode of dying, such as cardia	ac or respiratory an	rest,	Approximate Intervat Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition	Grafi		15 HOST			Some and Death Some Weeks
	resulting in deeth)	Due to	or as a consequence of	f): •			one wear
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cate be executed physician and the burial-transit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
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death cert e attendin ad for use							
d by th Setacher	Part II. Other algnificant conditions cont	ributing to death but not res	sulting in the underlying	cause given in Pert I.	23b. Did t	1.	tribute to the cause of death? 3 Probably 4 Unknown
or Attanding Physician: The law requires that the alreadeath. Jine death. Jin by the funeral director, page 2 should be deteched to be the funeral director. Page 2 should be deteched to be the funeral director.					24a. Was perfor	en autopsy med?	24b. Were eutopsy findings available prior to completion of cause
he lav e has age 2					101	es 200No	of death?
entificat sctor, p	25. Was case referred to medical			26. Place of De	eath (Check only o		70
hysic hysic his call direction To I	TU Yes ZUTNO		ER/Outpatient 3		Home 5 ☐ Resid		
After t funera	27. Menner of Death 1 Netural 5 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe h	low injury occurre	d
Living of Attaching Physician: The law fair death of Attaches: After this certificate has led in by the funeral director, page 2 Certification: To Be Comp	2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact		28f. Location (S City or Tow	Street and Number m, Stete)	r or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert				od at the time, date and place on, in my opinion, death occ			
Within To the	29b. Signature and title of certifier		2	29c. License number		29d. Date signed	(Month, Day, Year)
- 3 - 0	· Une En	raidonad	MD I	2133391		July	20, RODO
	30. Nama and address of person who con	npleted cause of death (Item		aene St	Balt.	Md	21201
State	31011 25 2000 Pear) Be	32. Registrar's Sign		9217			

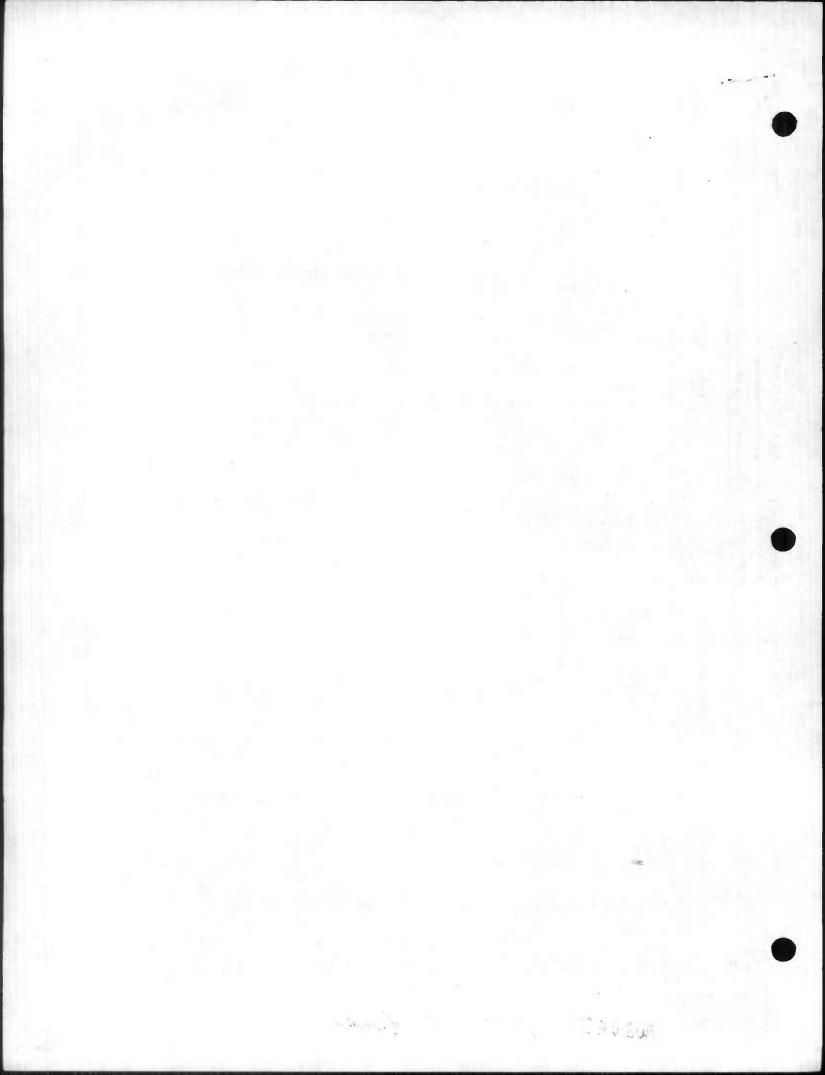


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Physician Month Gregorio Gonzalez 7/30/2000 07:05 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 2/16/1934 9. Birthplaca (Stata or Foraign Country) San Salvador 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 15 M 20 F 217-21-8664 Vrs 66 Director Usual Rasidence of Decedent 10b County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director MD Montgomery Rockville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1713 Yales Place 20850 El Salvador Funeral 14. Raca - Amarican Indian, Bleck, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puarto Rican, atc.) 11 Meritel Stetus Wes Decedent Ever in U,S. Armed Forcas? hours after 1 ☐ Never Married 2 ☑ Married 1 Yas 2 No 1 Tyas 2 No Specify: Salvadoran Baltimore, Maryland 21215-0020 PY 3 ☐ Widowed 4 ☐ Divorced Hispanic Completed 18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Supervisor Warehouse 12 should be filed w h and Mental Hygier Is marked other th 17. Father's Nema (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Surname) Be peamit. Pages 1 and 2 should be bepartment of Health and Mental Important: If Nem 27 is marked of any Injury or other traumatic events. Simeon Gonzalez Celsa Hernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 113 Wellow Dale, Frederick, MD 21072 Mirna Mejia, Daughter 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata cemetery, cremetory or other place) 1 Deurlal 2 Cramation 3 Ramoval from Stata Gates of Heaven 4 Donation 5 Othar (Specify) 8/5/00 Silver Springs Taylor's Funeral Home 21. Signature of Funaral Sarvice Licansee 22. Nama and Addrass of Facility 1722 N. Capitol St, NW, Wash., DC 20001 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one-gause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in death) Metastic Carcinoma of Unknown Primary 6 months Examiner Due to (or as e consequence of): certificate be axecuted Sequentially list conditions, if eny, laeding to immadiata cause. Enter Undarlying Cause (Diseasa or Injury that initiated events rasulting in death) Last and Due to (or es a consequence of): Box 68760 Physician/Medical the Due to (or as a consequence of): attending | P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 ☐ Yes 2√2 No 3 Probably 4 Unknown Records. by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy peen certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) axaminar? Other: 4 Nursing Homa 5 Residence 6 NOther (Specify) 2 1 ☐ Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mennar of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Describe how tnjury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yas 2 No 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida edical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.

2 Medicat Examiner: On the basts of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of petitier D0037620 7/30/00 30. Name and actiress of person who completed causa of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Mark S. Godec, M.D., Casey House, Rockville, MD 32. Registrer's Signatura 31. Data filed (Month, Day, Year) State Sporth Registrar DHMH 16 Rev 6/95

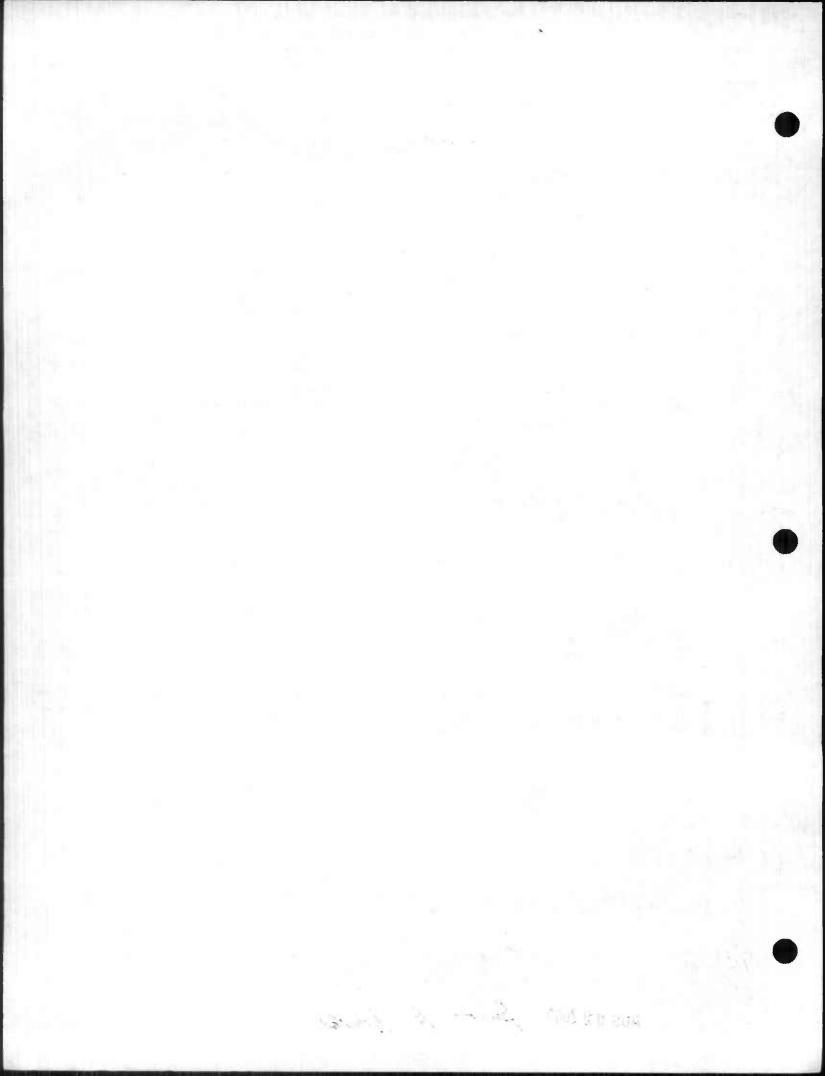


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

26080

Physician /Medical	1. Decedent's Nemo	e (First, Middle,	David B	lair Ga	rrett					2. Dete of Month July	29	9 2	Year 2000		of Death
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Funeral	5. Sociel Security N	umber 6	S. Sex	7. Age (in yrs.		If Under	er 1 Yeer		24 Hrs. Min.	8. Date of I	Birth Day, Year	()	9. Birth	plece (Star	te or Foreign
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Director	10e. Street and Nur	mber				10f. Z	ip Code						Whet Cou	ntry?	
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by Funeral	11. Meritel Status 1 Never Marri 3 Widowed	ied 2 Merried	12. Was Dec Armed F d 1 X Yes If Yes, G Year or	cedent Ever in to forces? 6/1 2 No live 1/1. Dates:			edent of Hi ecify Cuba 2 X No			ecify Yes or Rican, etc.)	No-	Ble	ce - Americ ck, White, by: Whi	etc.	
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State of Maryland / Department of Health and Mental Hygiene 2608 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29^{Pay} July **Physician** 2000 John Earle Godwin 7:30 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner 10518 Nast Drive Cheltenham Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplaca (Ste Country) | Sept. 29, 1915 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Months 10M 2□ F 220-12-1259 84 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits flems 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Prince Georges Cheltenham Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10518 Nast Drive 20623 United States Funeral filed within 72 hours after death Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 15 Yes 2 No 1942— If Yes, Give Yeer or Detes: 1945 1 Never Married % Married Maryland 21215-0020 5 1 ☐ Yes 2 ☐No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry then. Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Construction 12 al Hygie other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be ind Mental Helen Cole is marked o Unknown 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s 10518 Nast Dr. Cheltenham, Maryland 20623 Mam 27 I Margaret Godwin Wife Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition August Date. 1 Burlal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6 2000 Md. Vets. Cemetery Cheltenham, Maryland 22. Name end Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, Maryland 23a-Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last The lew requires that the death certificate be execu Box 68760. been signed by the attending physician Due to (or as a consequence of) use as the P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco ues contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown py of Vital Records. 90 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed N/A has 2200 1 Yes 1 ☐ Yes 2 ☐ No this certificate Attanding Physician: 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2 20 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA apital or Attanding Physical steel death.

neral Director: After this y filled in by the funeral di 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) end menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of cartille 29c. License number 29d. Date signed (Month, Day, Year) 90 919 wg. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) < e

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 1 2000

32 Registrar's Signature

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An	end #'s	State of Maryland / Department of Health and N 17.& 18. Per Fam.PGC 8-14-2000 cr Certificate of Death		iene	26082
400	Physician	Decedent's Nama (First, Middle, Last)	2. Dete of Death Month July 29	h Day	3. Time of Death 4:03a.m.
	/Medical Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Lo Prince Georges Hospital Cheverly	eth.	4c. County o	
	Funeral Director	5. Social Security Number 227–34–6859 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	8. Dete of Birth (Month, Day, Oct . 11,	Year)	9. Birthplace (State or Foreign Country) Halifax, Va.
	Mand	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	,		10d. Inside City Limits
	a Mar	Md. Prince Georges Cheverly			1 ☐ Yes 2 🖾 No
	t with the Ma Se or 28a-1 at La notified at Directo	10e. Street and Number 10f. Zip Code 6413 Landover Road 20785		og. Citizen of Wr U.S.A.	nat Country?
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Maryland 21215-0020	ed within 72 hou ygiene. wer then "neture is, the Medical E. Completed		king	16b. Kind of Busi	iness/industry
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altimore,	Pages 1 ant of H at: if the ry or off	20a. Method of Disposition 1 Burlel 2 Cramation 3 Removel trom State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) No. Va. Crematory	Date 2 8-1-00		ngton, Va.
Balti	Departm Departm Importa any Inju		illip Be	ll Fune	ral Service
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	April 2000	ist,	Approximate thervat Between Conset and Death
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Ö	tal or Attending P is after death. al Director: After led in by the funers Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)	28t. Location (Str. City or Town,	reet and Number , State)	r or Rurat Route Number,
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	within 2 To the comple	29b. Signature and title of custifier 29c. License number D R D V	29	7 31	(Month, Day, Year)
	(4)	30. Name and address of parson who sampleted cause of death (Item 23a) (Type, Print) Town ACA Sharper	delova	ly Ma	2085
	State Registrar	31. Date filed (Month, Day, Year) AUG 0 2 2000 33 Registrer's Signeture			

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al or		Social Security Number	6. Sex 11∑ M 2□		In yrs. last birthday 52 Yrs.) If Unde Months	Deys	If Under: Hours	Min.	8. Date of Bir (Month, De 02/17	th y, Year) /1948		place (State or Fo
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		. Method of Disposition	• 🗆 🗆		20b. Place of Disp cemetery, cre	osition (Ne	me of other plea	9)		Date	20c. Location	on - City or T	own, Stete
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	21.	Signature of Funerel Service	Licansee						y Adv	ent Fu	neral	& Cren	nation Sv
		MUSULLINE	masva	300								Virgir	ia 22046
	23a	 Part1. Enter the disease, or shock, or heart failure. List 	r complications to only one cause	that)caused the on each line.	e death. Do not er	nter the mo	de of dying	g, such as	cardiac c	or respiretory a	rre <i>s</i> t,		Approximate interval Between
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMend# 1 per Phy 8/4/00 AACO HEALTH CMH Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Lois Joyce Gleaves **Physician** Gleaves 30 LOIS Joyce Cleaves Jule 2000 /Medical 4b_City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore heudhnis HOPF DIALS HOS P19 If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys 1□ M 21 F 579-96-7194 Dec 21, 1943 China Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Director Arnold 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 840 Meadow Heights Lane 21012 Funeral 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stelus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name end Address of Fecility

Secretary

20b. Plece of Disposition (Name of

cemetery, crematory or other place Metro Crematory

Physician /Medical

Funeral

Director

Nerna 23a or 28a-f.

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Maryland 21215-0020

Saltimore,

Box 68760.

P.O.

Division of Vitai Records.

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Pages 1 and 2 s ment of Health an

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Department of Health a Important: If then 27 is any injury or other trau 9058.

the Medical Examiner must be notifi-

Immediate Cause (Final disease or condition resulting in death) Examiner The law requires that the death certificate be execu

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Be Completed

Medical Certification: To

this certificate has

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To the Hospital within 24 hours a To the Funeral Completely filled

l or Attending Physician: after death.

Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thal initiated events thal initieted events resulting in death) Last

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State

College (1-4or 5+)

Elementery/Secondery (0-12)

17. Father's Neme (First, Middle, Last)

Antonio P. Xavier

20e. Method of Disposition

19a. Informent's Neme/Reletionship (Type, Print)

Frank Gleaves/Husband

4 ☐ Donetion 5 ☐ Other (Specify)

23a. Pertt. Enter the dise in a composition that or and the deeth. Do not enter the mode of dying, such as cerdiec of respiretory errest,

Approximate - Stage Cardio myopathy ~ 2 years Due to (or es a consequence of): Coronary artery disease year Due to (or as a consequence of) Renal dys function
Due to (or es e consequence of): Severe obstructive pulmonary disease

18. Mother's Neme (First, Middle, Maiden Surneme,

Gertrudes M. Desouza

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

840 Meadow Heights Lane, Arnold, MD 21012
of Disposition (Name of Dete 20c. Location - City of Town, State

Aug 4

2000

Barranco & Sons, P.A. Severna Park Funeral Home

16b. Kind of Business/Industry

Research

Baltimore, MD

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Tetralogy of Fallot 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? ventricular Tachycardia Atrial Fuller and Fibrillation 1 ☐ Yes 2 ☑ No 1 Tyes 2 No 25. Wes cese referred to medice! axaminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 SInpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 28b. Time of 28d. Describe how Injury occurred

28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1. Netural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certifier

29c. License number 29d Date signed (Month, Day, Year)

07/30/2000

Indihab, MD, PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Ardehali, MD, PhD, Johns Hopkins Hospital, Baltimore, MD

State Registrar 31. Dele filed (Month, Day, Year) AUG 0 2 2000

32. Registrer's Signeture

RES-000

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 8 2m /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner udence devick 10) ann If Under Months 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 89 Days 322-24-8550 1□M 2\ F Illinois 24, 1911 Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Naples 1 Yes 2 No FL Collier Director 288-7 8 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? f 8 83 Cotton Wood Lane 33962 U.S.A. therms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo if Yes, Give Yeer or Deles: 14. Race - American Indian, Bleck, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Plegos 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiens. Important: It lears 27 is marked other than "natural", or less any injury or other traumette. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: py 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) Book Keeper Retail Store Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Albert Dambacher Pauline Heym 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4800 Great Oak Rd. Rockville. Md. 20853 Robert Glasby (Son) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Aug.9, Burial 2 Cremation 3 Ram Smithsburg Crematory 4 Donation Smithsburg, Md. 5 Other (Specif 2000 21. Signature of Funerel Service Lig 22. Name end Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximete tnterval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final e by cucycular disease or condition resulting in death) Examiner Examiner Scl 240 The law requires that the death certificate be asscuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. ten Dev Physician/Medicai Due to (or as a consequence of): for usa Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tobacco use contribute to the cause of death? P.O. 2 No 3 Probably 4 Unknown xxc SI Division of Vital Records, by Completed 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? page 2 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: funeral director. 25. Was cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) 1 Yes 20 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 1 Natural
2 Accident 5 Pending after deeth. Director: Aft 1 ☐ Yes 2 ☐ No investigetion the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi 0

State Registrar

DHMH 16 Rev 6/95

AUG 1

30. Nama and address of

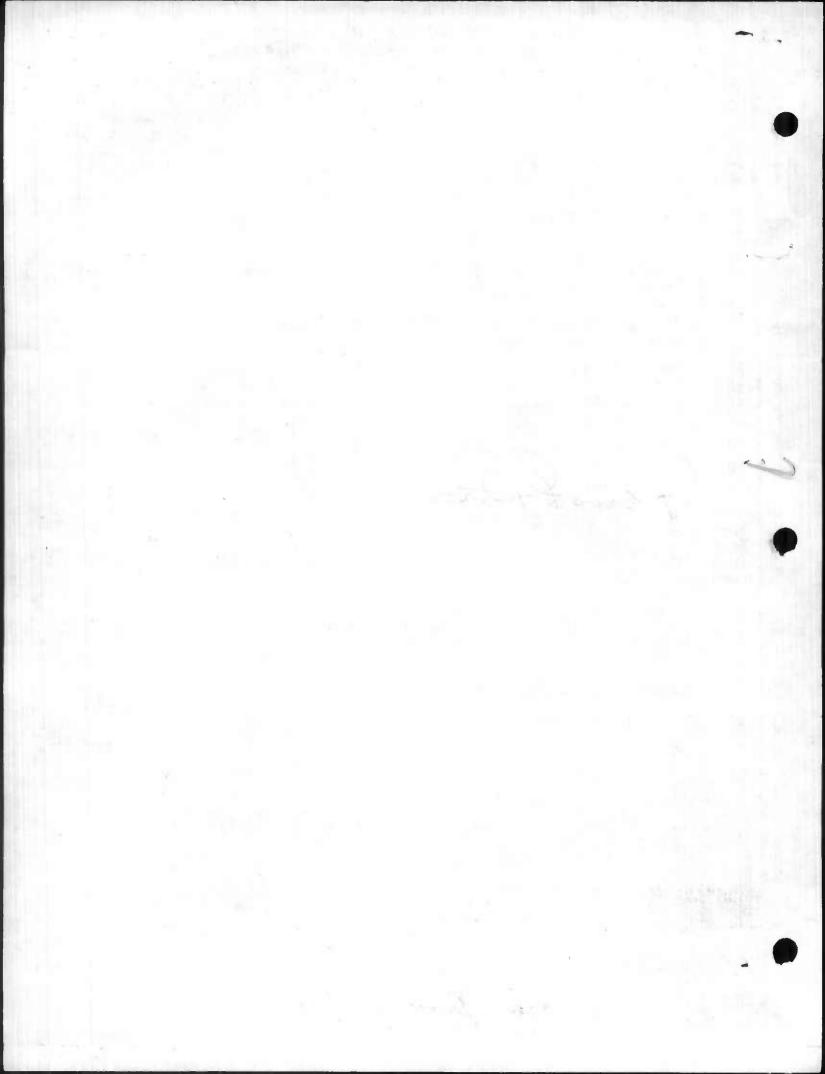
31. Date filed (Month, Dey, Year)

SUITE ZOZ

person who completed ceuse of deeth (Item 23a) (Type, Print)

MO 21702

172 THOMAS JUHNSON DRIVE FREDERICK



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last 2 Data of Death 3. Tima of Death **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give stree Examiner If Undar 1 Yaar **Funeral** Days 1 M 2 F Country) Virginia Director the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits ortant: If item 27 is marked other then "natural", or items 23s or 28s-f show injury or other traumstic event, the Medical Exampler must be notified at Maryland 1 ☐ Yes 2 No Baltimore. Director Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 8 Juliet Lane U.S.A. 21236 Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates: 14. Race - American Indien, Btack, Whita, etc. 11. Maritat Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours after 1 ☐ Nevar Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No þ White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Decedent's Usuat Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Depertment of Health and Mental Hygiene Important: If item 27 is merked other than "n any injury or other traumatic anaw entary/Secondary (0-12) Collaga (1-4or 5+) 12th Grade Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Unknown Unknown 19a. Informant's Name/Ratationship (Type, Print) 19b. Meiting Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Russell W. Gledhill (son) 8416 Timberland Circle, Ellicott City, MD 21043 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 ☐ Buriet 2 ☐ Cremation 3 ☐ Removal from State 7/31/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Green Mount Crematory 21. Signatura of Funaral Service Ltcensee 22. Nama and Addrass of Fecility
Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset end Death **Physician** /Medical Immediate Causa (Final disaasa or condition resulting in daath) Examiner the buriel-transit Saquentially tist conditions, if eny, leading to immediata causa. Entar Undarlying Cause (Diseasa or Injury that initiated avents resulting in daeth) Lest and Box 68760. attending physician Physician/Medical USB BS jo P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yae 2 No á 3 Probably 4 Unknown been signed should be det Records, p The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? page 2 certificata has 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

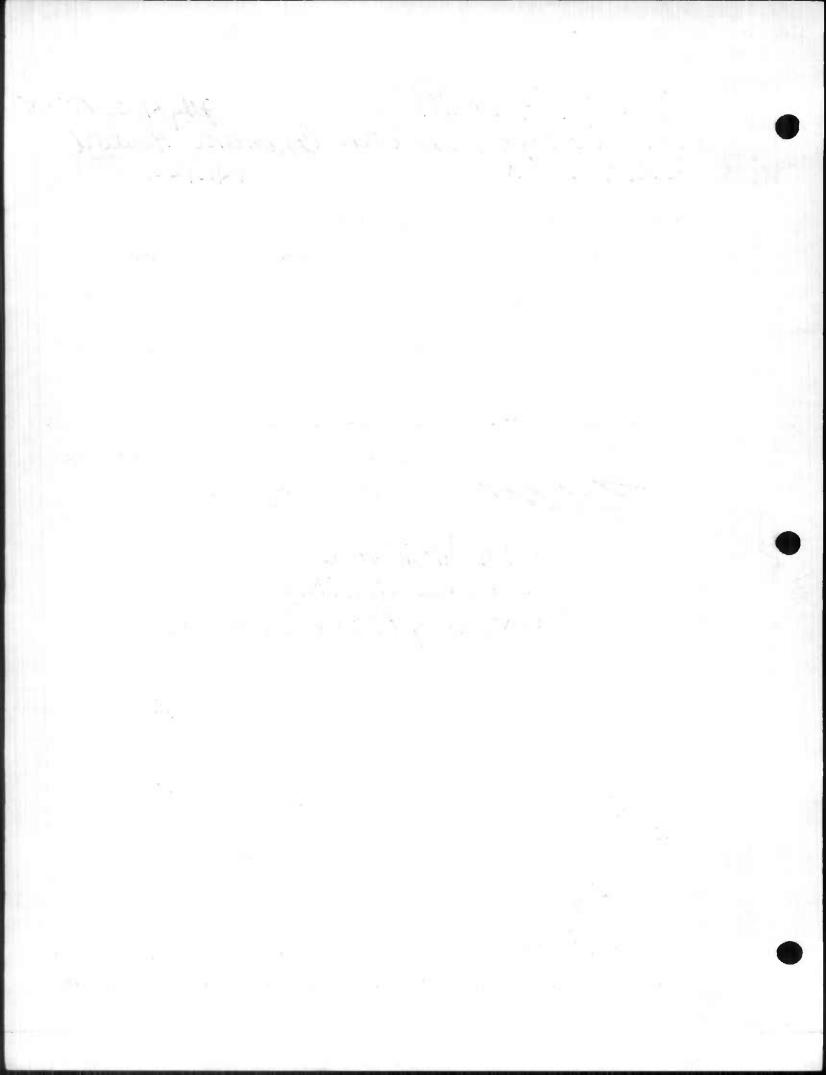
To the Funeral Director: After this certifice 25. Was casa rafarrad to medical axaminar? Be 26. Place of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital; 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No To 27. Manner of Death 28c. Injury at Work? 28b. Tima ot 28d. Describe how Injury occurred Medical Certification: 1 Natural 5 Panding invastigation 1 🗌 Yas 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) Placa of Injury - At homa, farm, streat, tectory, office building, atc. (Specify) 4 Homicide 12 Cartifying Physician: To the bast of my knowledge, death occurred at tha time, date end place, end dua to tha causa(s) and manner as steled.

2 Medical Examinar: On the besis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) 29a. Certifier 2 Medi¢ and mannar stated. 29b. Signature and title of 29c. Licansa numbar 29d. Data signad (Month, Day, Year) 10 30. Name and addrass of person who completed causa ot death (Itam 23a) (Type, Print) Colonbia MO 2 Knoll Watzy W7/104m OM MANA C 31. Data filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month **Physician** 7:25PM August William Richard Hooper /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yis. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 11, 1914 9. Birthplace (State or Foreign Country) Virginia 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number Days 217-14-7194 86 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Washington 1 Yes 2 No District of Columbia Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 20002 United States 206 Ascot Place, N.E. Funeral 12. Was Decedant Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Black 1 Yes 2 No à 3 ☐Widowed 4 ☐ Divorced Yaar or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Truck Driver Private 4th 17. Fathar'a Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Mary Johnson Richard Hooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1280 Daingerfield Landing, Champlain, VA Hurley T. Hooper - Nephew 20b. Place of Disposition (Name of cemetary, crametory or other place) Park 20c. Location - City or Town, Stata 20a. Mythod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Maryland National Mem. 8/8/2000 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Fameral Sarvice Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. her the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Causa (Final EMAS disease or condition resulting in death) Dua to (or as a consequence of) Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy 20 No. 1 Yes No 1 Yes 25. Was cese referred to medical examinar? 26. Place of Death (Check only ona) 1 Yes 2 No Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident

/Medical Examiner USB as 2

P.O. Box 68760.

of Vital Records,

Division

Physician

Funeral

Director

Hems 23a or 28a-f

8

Pages 1 and 2 should be fit ment of Health and Mental H lant: If them 27 is marked off jury or other traumatic even

21215-0020

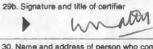
Baltimore, Maryland

page 2 this After

or Attending Physician: The law requires that the death certificate be executed after death.
Director: Aft
d in by the fur To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

5

Registrar



6 Could not be detarmined

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATHUR

IPUING STREET, NW 106

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

WASHINGTON OF 20010

31. Date filed (Month, Day, Year) AUG 0 4 2000

3 Suicide

29a Certifier

4 Homicide

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 26088 Certificate of Death 1. Decedenf's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Haynes Tola Mae July 1050 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's 5703 Birch View Place Clinton If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (Ste Country)
March 28,1912 Florida 9. Birthplace (Stete or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1□M 2KDVF Hours Months 88 Director 144 12 1805 Usual Rasidence of Decedent 10a, State New 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☑ No Director 288-1 Monmouth Freehold Jersey 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 07728 United States or Berns 23s 5 Avenue A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 X No Specify: Specify: à 3万Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home 8th Murses Aid permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if Item 27 is marked other any Injury or other trauments of the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Sheffield Roland Pompey 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 5703 Birchview Place, Clinton, Maryland 20735 (DAUGHTER) Pequoia Evans 20e. Method of Disposition 20b. Piece of Disposition (Name of cematary, crematory or other piece) Aug 5, 2005 20c. Location - City or Town, Stata X Burial 2 Cremation 3 Removel from State 4 Donation 5 Othar (Specify) Vernon, Florida St. Lukes Church Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature Alexandria Ferry Road, Clinton, Maryland 20735 Enter the disease, or complications thet caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Atheroscherotic Cardiovaseulas Disease /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner sician and burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical Due to (or as a consequence of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yes 2 No Records, been signe should be à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? **Dage 2** TTYes 20 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1₽ Yes 2□ No Certification: To Horre 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Mennet of Death 28b Time of 28c. Injury at Work? or Attending 1 Natural 5 Pending 1 TYes 2 □ No death. investigation 2 Accident 24 hours after deat Funerat Director: 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical completaly (Check only one) within 2 \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1400,55 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) ve, cheverly, Maryland 300 Hospital SULVESTER SALVADON 31. Date filed (Month, Dey, Year) 22. Registrar's Signature State AUG 0 2 2000 Registrar

DHMH 16 Ray 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death Amend# 26.Per Phys.PGC 8-2-2000 2. Date of Death M97/29/2000 Arthur Hawkins 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Gleneagles Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Age (In yrs. last birthday) Days XXM 2DF Months 62 Yrs 10 - 17 - 37iOc. City, Town or Location 10b. County PG Fort Washington 10f. Zip Code 10g. Citizen of What Country? 20744 USA 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yest ANO Specify: Specify: Black 16b. Kind of Business/Industry

3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:50 AM James /Medical 4a Facility Name (If not institution, give street end number) Examiner 722 Birthplace (Stete or Foreign Country) 5. Social Security Number **Funerai** 219-34-8339 Director Pomfert.MD. Usual Residence of Decedent the Marylend 10d Inside City Limits 10a State 28a-f ahow notified at MD X1 - Xex 2 No Director 10e. Street and Number with "naturel", or items 23a or address Exemples results be a 722 Gleneagles Funeral 72 hours aftar death 11. Marital Status 1 Never Married __2 Married Maryland 21215-0020 py 3 □ Widowed 4 □ Divorced Completed treumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 73.
Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other treumatic event, the Median Once. Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Hairstylist 18. Mother's Name (First, Middle, Maiden Sumeme) 17 Father's Name (First Middle Last) Be Alex Hawkins Rose M. Hall Lo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stalk Qip Coulb) 19a. Informent's Name/Relationship (Type, Print) Joyce Hawkins/Wife 722 Gleneagles Drive Ft. Washington, Md. Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection 8/4/00 Clinton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20020 Wm.F.Magruder FH 2311 MLK Jr.Ave.SEWDC Part Enterthe disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, hock, or man failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician end the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) 83 ettending USB 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy Completed been s AM has 1 Yes 2 No 1 Yes 20 No

page 2 cartificate director, After this

Be

10

Certification:

The Division of Vital Attanding Physician: daath. Director: in by the Hospital or At 24 hours after of

To the Hospus.

Within 24 hours after
To the Funeral Dire edical 6

State

31. Date filed (Month, Day, Year) Registrar

25. Was cese reterred to medical

290. Signature and title of pertified

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Menne of Death 1 DNatural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern AVRIUR SE

28a. Date of injury (Month, Dey Year)

#312 Washington

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

26. Plece of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6-

> 29d. Date signed (Month, Day, Year) 2000

32. Registrar's Signature AUG 0 2 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26090 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Josephine Hart Amv July 5:25 AM 31 2000 /Medical 4c. County of Death 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mariner Health of Forest Hill Forest Hill Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 2₩ F Months Hours 77 Director 218-16-0073 July 3,1923 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location t 0d. Inside City Limits r than "natural", or liams 23s or 28s-f shorthe Medical Examiner must be notified at the Maryt 1 Ves 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1106 Volos Court 21015 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, 11. Meritel Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merrled Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Government Secretary 12th peimit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important; if Nem 27 is marked other. Any Injury or other treasment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Susie Hill George Brooks, Sr. 0 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rosetta Phillips/Sister 1106 Volos Court, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 08/04 1 ₩ Burial 2 Cremation 3 Removel from State Lincoln Memorial Cemetery 2000 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signetule of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel Leiners diaease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner bunial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial P.O. Box 68760 that the death certificate be Physician/Medical Due to (or es a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the been signed by is should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 has 214 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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33. Registrar'a Signature

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Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY 30, 2000 5:05An Myrtle G. Hunt /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Doctors Hospital Prince George's Lanham H Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) July 12, 1904 7. Aga (In yrs. last birthday) 96 Yrs. 9. Birthplaca (State or Foreign Country) South Carolina 5. Social Security Number **Funeral** 1□M 2⊠F 419-10-2255 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Prince Georges Temple Hills Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2511 Afton St. 20748 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritaf Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2♥ No Specify: à 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Federal Government Librarian 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Golden Annie Whitaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health them 27 i 2511 Afton St., Temple Hills, MD 20748 Michael Moran/Executor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 8/4/2000 Clinton, Maryland Resurrection Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 alus 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Atheroscleptic Cardio Vascular Disease /Medical Examiner Due to (or as a consequence ot): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Box 68760, that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. 1 Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given In Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yea 2 No 3 Probably 4 Unknown of Vital Records, by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to complation of ceuse of death? Completed 2 DNo 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Dipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28d. Dascribe how Injury occurred 28c. fnjury at Work? Division or Attending 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 039550 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Hayar, Jr. M.D. 4850 Forbes Blud Lankam, Md 20706 George C.

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

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72. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 00 26092

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DHMH 16 Ray 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26094 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician George A. Harrell July 25, 2000 8:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11 M 2□ F Days 577-07-4116 Director Jan. 30,1909 Marshall.VA Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. tnside City Limits Maryland | Prince George's 1 Yes 2 No Oxon Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1324 Crisfield Drive 20745 USA 12. Was Decedent Ever in U,S.
Armed Forces?

10 (Yes 2 | No WIII
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White d 2 should be filed within 72 hours aft th and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exami 3℃Vidowed 4□Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Electrician Train Station 9th Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be frent of Health and Mental 9 nt: If them 27 is marked of Sounders Harrell Adelaid Fewell 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte A. Niess/Niece Same as item 10 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/28/2000 4 ☐ Donetion 5 ☐ Other (Specify) Suitland, MD. 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signature of uneral Service Licensee aley 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part 1. Enter the disease, or compliant that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** more than /Medical tmmediate Cause (Final Metastatic disaase or condition resulting in deeth) 6 mon try **Examiner** Approx. ostate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Cerebro - Vascular Accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? COPD-Atheroscienotic Cardio Vascular disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: Mining Home 5 | Residence 6 | Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 Yes 2 No investigation 2 ☐ Accident after deat Director: 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide a Funeral E 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

To the Within 2 To the 10

DO C

31. Date filed (Month, Day, Year)

JUL 3 1 2000 State Registrar

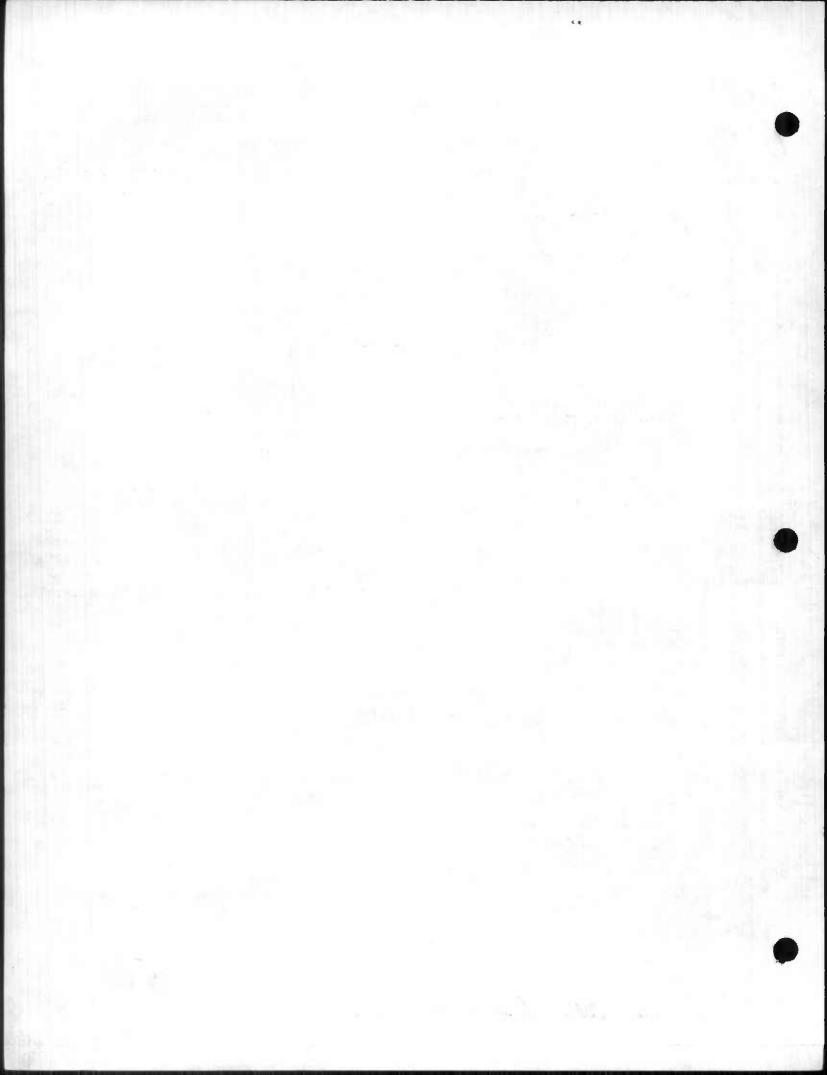
29b. Signature and title of purifier

32. Registrar's Signature

29c. License number D 50653 29d. Date signed (Month, Day, Year) 7-26-2000

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 5851- Dealechurchton Road

SURANA- MD GXAN.C. Deale.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 3 Pey **Physician** 1:00pm 2000 HALL WILKEY HELEN /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Montgomery HOSPITAL Olney GENERAL MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 3 10 1920 9. Birthplece (State or Foreign Country) Tennessee 7. Age (In yrs. lest birthday) **Funeral** 1□M 2XF Months Days Hours Min Yrs. Director 12 1591 Usuei Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumetic event, it a Market Express. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Spencerville Md Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number U.S.A. 20868 15801 Phillips Oak Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à 3 X Widowed 4 ☐ Divorced **Black** Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Federal Govn't 12th Secretary 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Weems Ida Wilkey Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1\,0\,8\,0\,0\,$ Riverwood Drive 19a. Informent's Name/Reletionship (Type, Print) Macy G. Hall Jr., Son Potomac Maryland 20854

20b. Piece of Disposition (Name of Dete cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 8/4/00 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Memorial Park Hyattsville, Maryland 21. Signature of Eugerel Service/Licentin 22. Neme end Address of Fecility 20001 HALL BROTHERS FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

1 Florida Avenue, NW, Washington, DC Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finei disease or condition resulting in deeth) Failure **Examiner** Examiner requires that the death certificate be executed physician end s the buriel-frans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, en tona TOL Physician/Medical Due to (or es e consequence of) 3 Weeks ettending pl Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by the 2 XNO 3 Probably 4 Unknown h 24b. Were eutopsy findings evelleble prior to Completed 24e. Wes en eutopsy performed? completion of cause certificate has b director, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 10 1 Yes Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner as stated.

| Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e, Certifier

10 State

Registrar

31. Date filed (Month, Dey, Year) AUG 0 2 2000

29b. Signeture and fittle of certifie

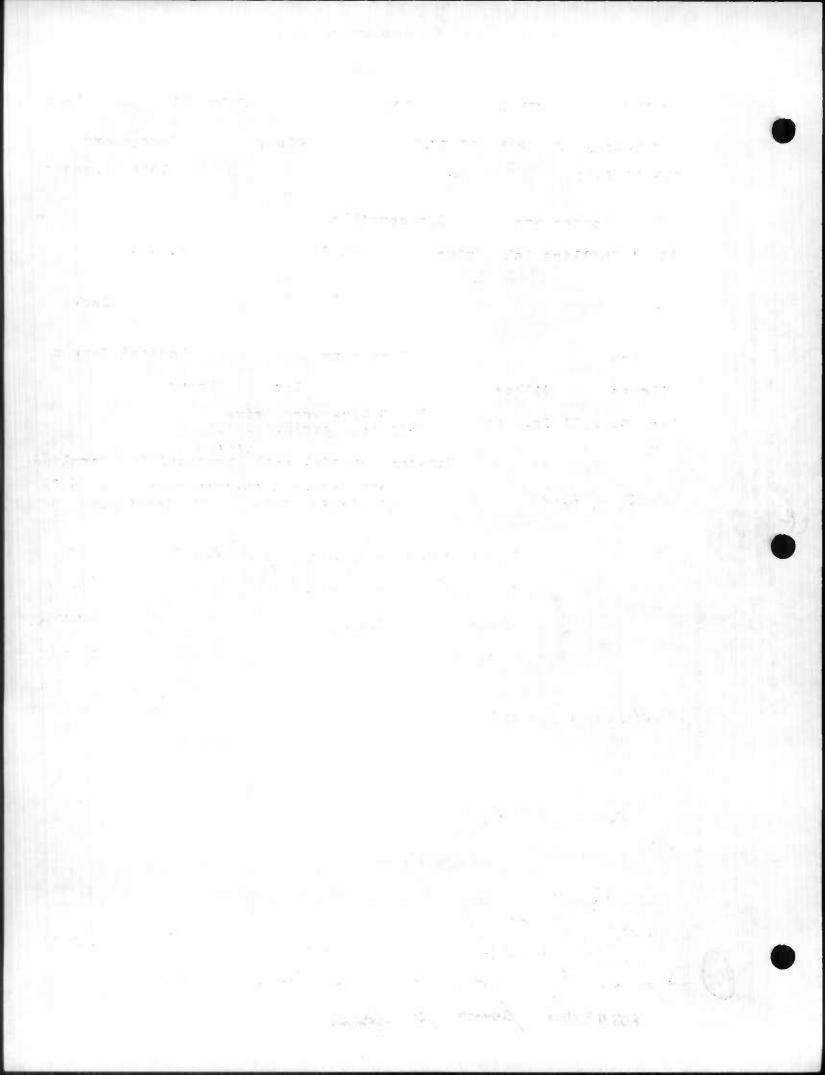
Masliano MD 18111 PRINCE 32. Registrar's Signeture

no completed cause of deeth (Item 23e) (Type, Print)

29c. License number 05/90

29d. Date signed (Month, Day, Year)

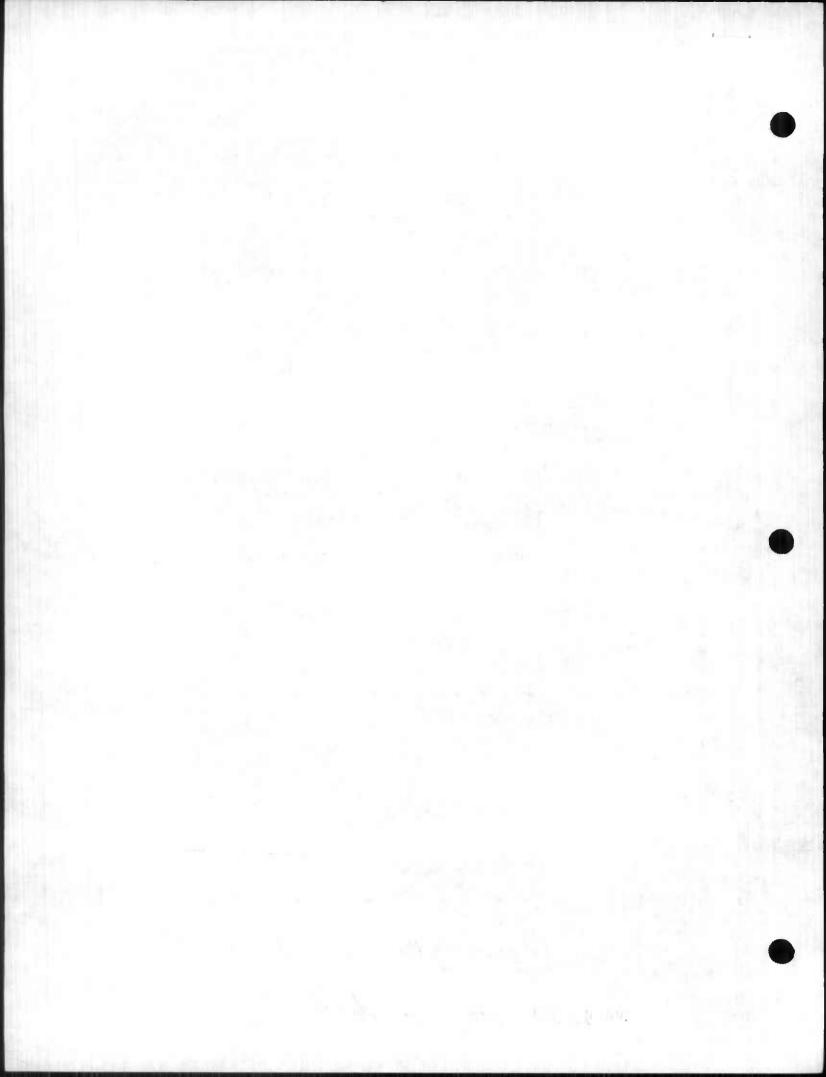
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Amended Line 19a WCHD CLZ 08/04/2000 Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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State of Maryland / [Depar	tment of	Health	and	Mental	Hygiene
	-					

	Certificate of Death	,	Reg. No.	26096
	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Day	3. Time of Death
Physician /Medica	Luwatu Liwiii iiaikitian bi	July .		000 2314
Examine	4h City Town of I	ocation of Death	4c. County	of Death
	Washington County Hospital Hagersto	own	Wash	ington
Funeral Director	5. Social Security Number 217-28-2121 6. Sex 1 Months 1 M	8. Dete of Birth (Month, Day June 23	, Year) , 1914	Birthpleca (State or Foreign Country) Germany
2 >	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
the Marylan 28a-f show notified at				1 ☐ Yes 2 ☑ No
the M 28a-f	Maryland Washington Hagerstown 10e. Street and Number 11320 Croopborry Road 21740		10- 02	
ath with t	10e. Street and Number 11330 Greenberry Road 10f. Zip Code 21740			SA
020 urs	11. Meritei Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Merried 1 Never Merried 2 No If Yes, Specify Cuben, Mexican, Puerto If Yes, Give Year or Detes: WWII	ecify Yes or No- Rican, etc.)	Specify	a - American Indian, k, White, etc. white
5-00°	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	kina	16b. Kind of Bu	siness/Industry
within then then	Elementary/Secondery (0-12) College (1-4or 5+)			
N Date	12 4 correctional counselor			of Correction
Maryland 2 d 2 should be filled th and Mental Hygi 7 le marked other treumatic event, it	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12 College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Julius Harriman 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) correctional counselor 18. Mother's Nem Anna	e (First, Middle, Behrendt		Θ)
re, Mary 1 and 2 sho 1 Health and N tem 27 le me other treume	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rur	ral Route Numbe	er, City or Town,	Stete, Zip Code)
	Margaret L. Harriman - wife 11330 Greenberry Road	, Hagers	stown, M	ld. 21740
0 80 = 2	20a. Method of Disposition 1 🖾 Burial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Mt. Hebron Cemetery 8-	Date - 3-00		City or Town, Stete ter, Virginia
Baltim permit. Pa Departmen Important: eny Injury			FUNERAL	
Ball Department of the property in the propert	415 E. Wilson Blvd			
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): b.	- Antop	xy Confir	my 4hrs
68760, ifficate be assecuted g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of):			
X eg eg	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. D) A Fed Cardiomy opa Hy			
O. the de tree	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ntribute to the cause of deat
P dela	Dilated Cardiomy sportly	10	Yss Z No	3 Probably 4 Unkno
Cord requir	25. Was case referred to medical examiner?		en autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
and Physician: The law After this certificate has turneral director, page 2 s		456	4 A D N	
Vital Relicion: The law certificate has rector, page 2		120	20	Yes 2□ No
f Vita	25. Was case referred to medical examiner? Hospital: Hospital: Other:			
hy hy	1 Inpatient 2 TEX Outpatient 3 DOA 4 Invising no		denca 6 Oth	
After funer	27. Magner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work? 1 Accident investigation 28c. Injury at Work? 1 Yes 2 No	200. 0 000.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division I or Attending efter death. Director: After d in by the fune	2 Accident 3 Suicide 4 Homicide Accident Investigation Suicide Could not be determined Could not be building, etc. (Specify) Could not be building, etc.	28f. Location (S City or Tox	Street end Numb vn, State)	per or Rurel Route Number,
Division To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: Affect completely filled in by the funeral	29e. Certifier 29e. Certifier (Check only) 29 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occur	, end due to the rred et the time,	cause(s) end ma date end place,	anner es stated. and due to the cause(s)
the	end manner steted. 29c. License number		29d. Date sinne	d (Month, Day, Year)
- 3 T 8	De C PARIS DA MAIN ON DE	7	815	100
	of Charles Mill Osto		0/0/	
	30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	Lager	(Hun	WD 71247
State Registra	ALLE A DOUBLE NOTE AND AUGUST			



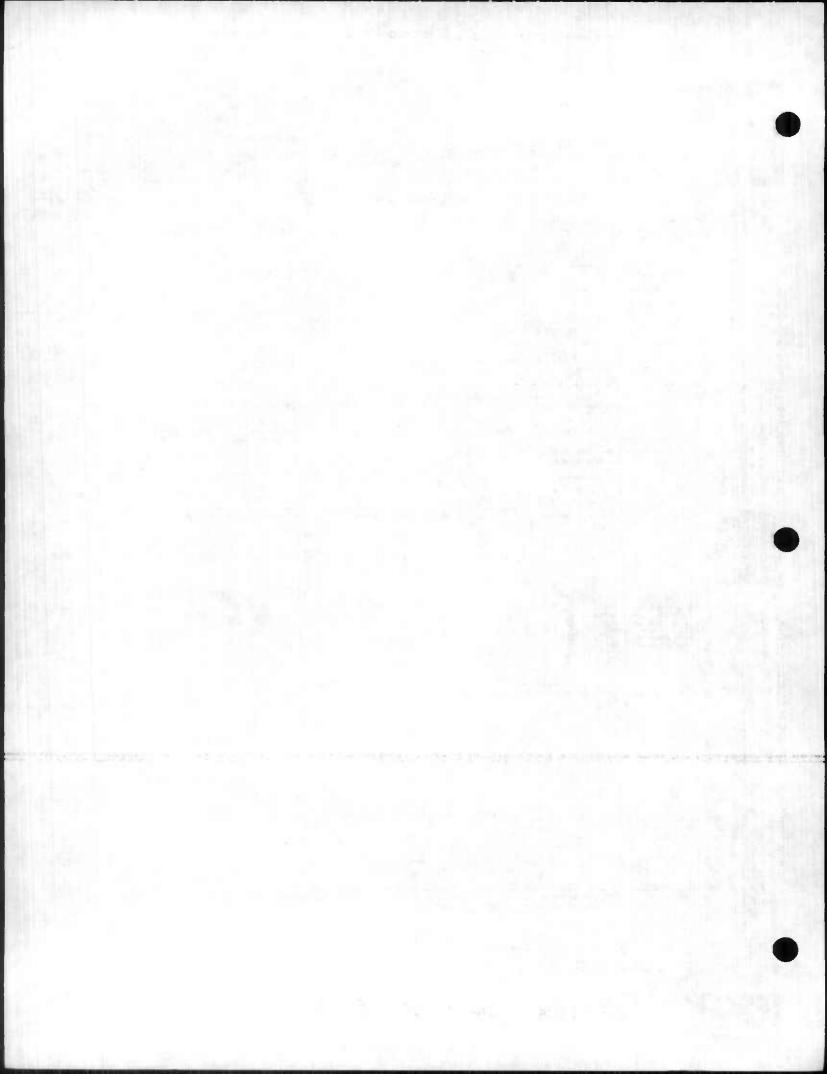
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death July 30, 2000 **Physician** Betty May HOLDER 9:32 a.m. /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Cavetown 12016 Mapleville Road 5. Social Security Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Dala of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months 1□ M 2⊠ F Deys Hours 218-24-8887 Yrs. July 8, Maryland 70 Director Usuel Residence of Dacedent with the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1₺ Yas 2□ No Funeral Directo Maryland Washington Cavetown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21720 USA 12016 Mapleville Road filed within 72 hours after death 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: white by 3₺ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry then. Elementery/Secondary (0-12) College (1-4or 5+) 0 dress factory seamstress other 1 Dearmeit. Pages 1 and 2 should be file. Department of Heelth and Mental Important: if fam 27 is many fully or other. other traumatic event. 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Isabelle unknown Richard Lawson Keller 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) P. O. Box 84, 12024 Mapleville Rd., Cavetown, Md. 21720 Christina Martin - daughter 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 8-2-00 Cedar Lawn Mem. Park Hagerstown, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funeral Sarvice Licensaa, MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician immediata Causa (Final disaasa or condition rasulting in death) /Medical liver metatasis Adenocarcinoma Examiner Due to (or es a consequence of): Physician/Medical Examiner use as the burial-transit The law requires that the death certificata be executed Sequentially list conditions, if sny, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last pue Due to (or es a consequenca of) Division of Vital Records, P.O. Box 68760, the attending physician Due to (or as a consequence of): To the Hospital or Attanding Physician: The law requires that the des within 24 hours after death.

With The Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? COPI 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24a. Was an autopsy 24b. Wara autopsy findings available prior to complation of cause of death? 1 Yes 250No 1 Yes 2 No 25. Wes case refarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: 1 ☐ InpatianI 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas Medical Certification: To 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28d. Dascribe how Injury occurred 28c. Injury et Work? Natural 5 Pending Invastigation 1 Yas 2 No 2 Accidant 6 ☐ Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifian 30. Nama and addrass of person who complated causa of death (Itam 23e) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year) AUG 0 2 32. Registrar's Signatura

2000



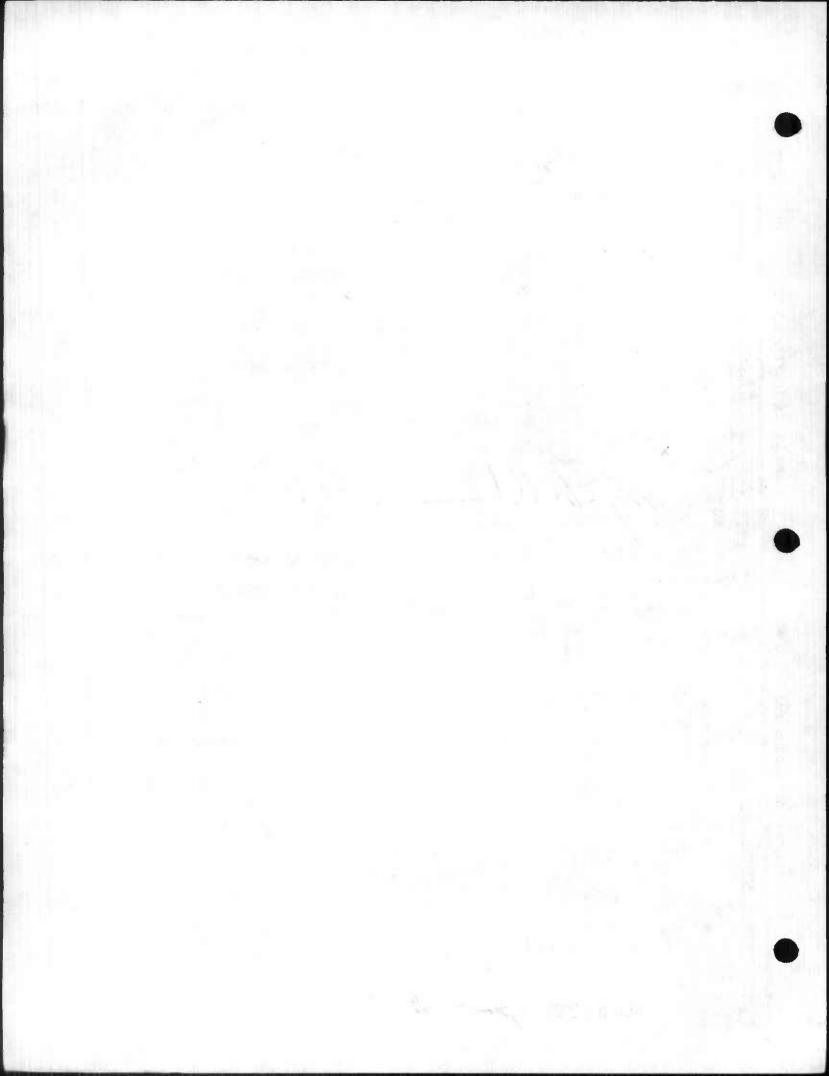
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State of Maryland / Department of Health and Mental Hygiene 26098 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** homas. M. Herbert tulle :10 my 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Washington Hagerstown H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 MM 2 F Director 215-26-2277 69 May 23, 1931 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ehow the Wedical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director Washington Hagerstown 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 407 Guilford Ave. 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Kor ea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indian, Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 M No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within: Department of Heelth end Mentel Hyglene. Important: if hem 27 I a marked other than "eny lijury or other treumatic event, the Head Botica. Elementary/Secondary (0-12) College (1-4or 5+) 10 Foreman Leather Processing 0 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) 8 George Herman Herbert, Sr. Gladys Elizabeth Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin L. Slocum (daughter) 310 Glendale Dr. Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greenlawn Memorial Park August 9,2000 Williamsport, MD 21795 22. Name and Address of Fecili OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final THEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Examiner obstructive AIRWAY DISTARTE oyears Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of): pue physician es the buriel-P.O. Box 68760. Physician/Medical Due to (or as a consequence of): for use as Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown noue Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? peen 2 X No 1 Yes 1 Yes No certificete Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours ster deeth. To the Funeral Director: After th completely filled in by the funera 28b. Time of 28c. Injury at Work? NIA 1 Natural 2 Accident 5 Pending 1 Yes 2 No NIA 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide MIR 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MOPA D2836 8.6.00 person who completed cause of deeth (Item 23s) (Type, Print) 1500 Pennsylvania Avenue 2 2 HARM Hagerstown, MD 21742 32 Aegistrar's Signature

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State of Maryland /	Department of Certificate or	Health and Mental F	lygiene O	26099
	Physic /Medi		Decedent's Name (First, Middle, Last) ELVA LUCILLE HINES			2. Date of Month AUGUS	Death Day	3. Time of Death
?	Exami		4a. Facility Name (If not Institution, give stre 19515 Meadowbrook			4b. City, Town, or Location of De Hagerstown	, ,	Death gton County
	Funeral Director		220-10-3314	7. Age (In yrs. last to 88	birthdey) If Under 1 Yee Months Dey:		Birth 7911	9. Birthplace (State or Foreign Countyland
	Marylend	ctor	Usual Residence of Decedent 10e. State 10b. County Maryland Washington		wn or Location	agerstown		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23a or 28	Funeral Director	10e. Street and Number 19515 Meadowbrook	Road	10f. Zlp Code	21742	10g. Citizen of Wh	ust Country?
020	n 72 hours efter death with the Maryland "natural", or frame 23a or 28a-f show effect Exprise must be notified at		11. Merital Status 12. 1 Never Merried 2 Married 3 🖾 Widowed 4 Divorced	Was Decedent Ever in U,S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💆 No	Hispanic Origin? (Specify Yes or ban, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race Bleck, Specify:	American Indian, White, etc.
21215-0020	within she.	Be Completed by	15. Decedent's Educat (Specify only highest grade of Elementery/Secondery (0-12)	lon ompleted) College (1-4or 5+) O		ipation e during most of working ed) maker	16b. Kind of Busi	ness/Industry sidence
Maryland	should be filed of Mental Hygis marked other imatic event, to	To Be C	17. Father'a Name (First, Middle, Last) John W. Stone			18. Mothar's Name (First, Mide Rosa Harbaugh		
	and 2 should seith and Men n 27 is marke er traumetic		19e. Informent's Name/Reletionship (Type, Richard D. Sheasle			Box 178, Blue I		
altimore,	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1X Burial 2 □ Cremetion 3 □ Rem 4 □ Donation 5 □ Other (Specify)	20b. Place cemel	of Disposition (Name of lery, cremetory or other pit Haven Ceme	ece) Date	20c. Location - C	
Balt	permit. Departr Importe any Inji		21. Signature of Funeral Service Licensee	Zuri		"A. Fiery Funera rn Blvd. N., Had		Maryland 21742
	Physician		213 Part Errier the disease, or complicate shock, or heary allure. List only one of	ions thet daused the death. Do ause on each line.	o not enter the mode of dy	ring, such as cardlec or respiretor	y errest,	Approximete Intervel Between Onaet and Death
	/Medicai Examiner		Immediata Cause (Final disease or condition resulting in death) a	ARRHYTHMII	a consequence of):	IOVASCULAR		JECONAS
	and I-transit	Examiner	Sequentially list conditions, if any leading to immediate	AT HEROS (LEA Due to (or as a	OTIC CARD a consequenca of):	IDVASCULAR	DIREAGE	YEARS
x 68760,	death certificate be executed e attending physician and of for use as the burial-transit	edical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest	Due to (or as a	a consequence of):			
s, P.O. Box	requires that the death certific seen signed by the attending p hould be detached for use as	by Physician/M	Part II. Other eignificant conditions contrib	outing to death but not resulting	In the underlying cause g		fd tobacco use contr	bute to the cause of death?
of Vital Records	aw 2 s s	Completed b	,			24a. W	orformed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital	Physician: The I this certificate harral director, page	Be	25. Was case referred to medical exeminer?	oital	T	26. Place of Death (Check on		1 ☐ Yes 2 ☐ No
o	Physic this c	. To	1 Yes 2 No Host	1 Linpatient 2 LEHVC	Dutpatient 3 DOA	ther: 4 Nursing Home 5	esidence 6 Other	

To the Hospital or Attending P within 24 hours after daath.
To the Funeral Director: After the completely filled in by the funeral Division Medical Certification

(Month, Day Year) 1 Natural 5 Pending investigation Injury Work? 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Exeminar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Year)

HAGERSTOWN, MD 21742

completed cause of death (Hem 23a) (Type, Print)

32 Registrar's Signature

State Registrar

30. Name and eddress of person who

PANELA FOX BP 31. Dete filed (Month, Day, Year), HUU 0 8 2000

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 07 **Physician** ANNA HODGES 26 2000 12:06 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HERITAGE HARBOUR HEALTH CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Oh10 **Funeral** Days Months Hours 1□M 2□F 89 167 01 3187 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits natural', or flams 23s or 28s-t show must be notified at VA Northumber Land Heathesville 1 Yes No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO BOX 246 USA 22473-0246 Funeral Wes Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck White, etc. hours after 1 Never Married 2 Merried WHITE Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Department Store 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental Hi tant: If them 27 is marked off Be 2 Ljubomir Zivkovic Ljubica Trvojevich 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If them 27 is any injury or other tree 12 N Southwood Annapolis, MD. 21401 Johanna Wilson/Niece 20a. Method of Disposition

14276urial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete Date cemetery, cremetory or other place) Monongahela Cemetery 7/28/00 North Braddock PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Advent Funeral & Cremation Services Willela Naggiu Annapolis MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate fntervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760 Physician/Medical ä Due to (or es a consequence of) P.O. Pert II. Other algriffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contributa to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was en eutopsy 1 Yes 2 19 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to rpedical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 Mp 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28e. Dete of fnjury (Month, Dey Year) 28c. Injury at Work? Aller Attending 1 (PNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident s Hospital or Atland 24 hours after death a Funeral Director; 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. Medical Medical Estimator: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Sign 29c. License numby HOSP A/ Cheval YMA dress of person who completed cause of beath (kem 23a) (Type Print) 30. Name and LUN 1avu 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State Registrar AUG 0 4 2000

Some B. fraid

AUE n 4 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a per phys G786 8/17/00 yg Certificate of Death Red. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Herbert Perlman Hoffman June 19, 12:05 PM 2000 /Medical 4a Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** VA Maryland Health Care System Perry Point Cecil 8. Date of Birth (Month, Day, Year) Aug. 24, 1923 If Under 1 Year 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Maryland Hours 219-14-0853 76 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 No 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 78 East Broadway 21014 U.S.A. "natural", or items 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1/2X/9s 2□ No 1/1 Yes, Give Year or Dates: 1941-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indien. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the last Elementary/Secondary (0-12) Six Years College (1-4or 5+) Never Employed Never Employed 17 Father's Name /First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Oscar Hoffman Augusta Perlman 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Albert Hoffman (Brother) 12555 Oaks North Dr., San Diego, California 92128 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cemetery 6/23/00 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. THELDOX Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Respiratory Failure 3 days Examiner Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA ician end burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria CARDIOPULMONARY ARREST Physician/Medical Due to (or as a consequence of): 82 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown The law requires that Schizophrenia þ 24b. Were sutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 TYes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 20 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c, Injury at Work? 5 Pending 1 Netural 1 Yes 2 No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

1 VA

Hospital

To the

21215-0020

Baltimore, Maryland

Box 68760

P.O.

Records,

Division of Vitai

HERBERT HOFFMAN

TO PHYSICIAN

KNOWN

State Registrar

3

filled in

completely

edical

31. Date filed (Month, Day, Year)

4 Homlcide

(Check only one)

29b. Signature and title of certifier

29a. Cartifier

D21779

Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

June 19, 2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

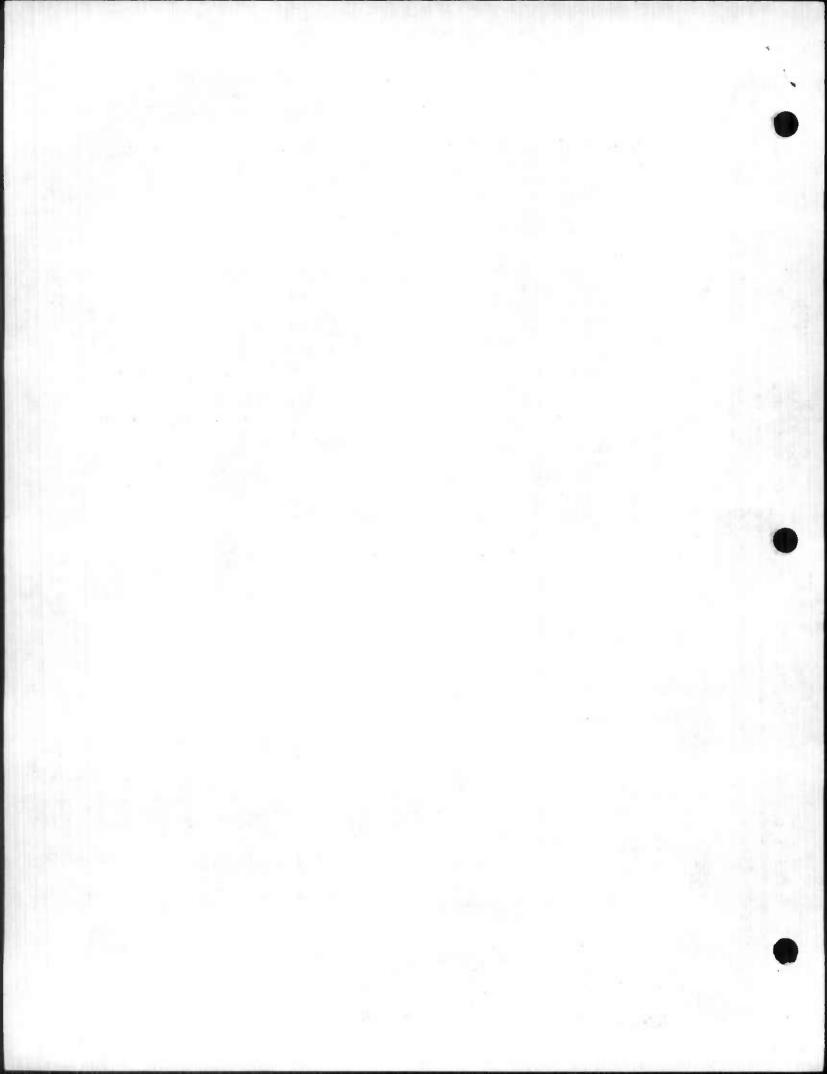
Teela

VIJAY NELLORE, M.D., VA Maryland Health Care System, Perry Point, MD 21902

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature JUN 2 2 2000

DHMH 16 Rev 6/95

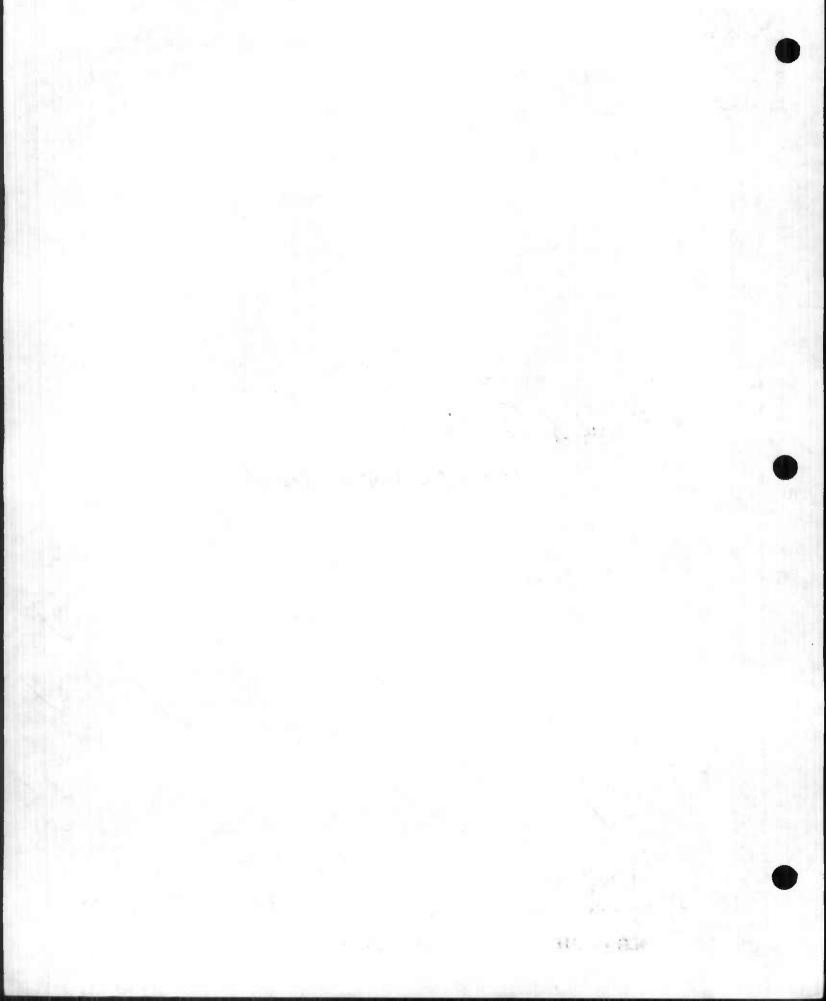


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State of Maryland / Department of Health and Mental Hygiene 00 26 102

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Funeral Director	5. Social Security Number 6. Security Number 214-34-2718	IM OKIE	2 Yrs. Months		Hours Min.	8. Dete of Birt (Month, De Aug. 1:	y, Year) 5, 1917 Nor	irthplace (State or Foreign Country) th Carolina
anytand show adat	10e. Stafe 10b. County		ity, Town or Location	0			74 11 2	10d. Inside City Limite 1 ☐ Yes 2 🕅 No
or 28a-fa be notified Director	Maryland C	ecil	Rising				10g. Citizen of Whet C	
	432 Stevens Road		101, 2	tip Code	911		USA	Southly?
42 should be filed within 72 hours after death with and Mental Hyglene. 7 is marked other than "natural", or flering 23a theunstic event, the Medical Examiner must To Be Completed by Funeral	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Detes:			lispenic Origin? (Sp en, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Specify:	
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Mental H Mental H inhed off edic even	Grover Clevela	nd Bell			Eunice	Blevin	S	
S and S	19e. Informent's Neme/Reletionship (Ty)	pe, Print)	19b. Meiling Addre	ss (Street	end Number or Ru	ral Route Numbe	er, City or Town, State,	, Zip Code)
and seth seth	Ray A. Hughes/Son		77 Fair t		and the same of th	kton, M	D 21921	
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Pag ment ury u	4 □ Donetion 5 □ Other (Specify)	На	rford Memor	rial	Gardens 8	-5-00	Havre de G	irace, MD
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been sign should be						24a. Wes	en autopsy 24b prmed?	Were autopsy findings available prior to completion of cause of death?
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l or Attending after death. Director: After din by the fune ertification	2 Accidant investigation		М		Yes 2□No			
ital or Attending Parts after death. Tel Director: After to led in by the funeral Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, atc. (Speci	nome, ferm, street, fectory)	ory, office	fice 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)			
To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29a. Cartifier (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of exemine and menner steted.	owledge, deeth occurra etion and/or investigation	d et the tir	ma, data end place, pinlon, death occur	end due to the red at tha tima,	cause(s) and menner data and place, and d	es stated. ua to the cause(s)
To the comp	29b. Signeture and title of certifier		2	9c. Lieens	in number 41 2		29d. Date Agned (Mo	nth, Dey, Year)
/	Y () Cy Sil	N		7	1011	75	1710	V
0	30/Name and address of person who co	mpleted cause of deeth (Item	m 23a) (Type, Print)	Ve	H	06	MN Y	850
State Registrar	31. Date filed (Month, Day, Year)	32, Registrer's Sign	eture 4		,			,

DHMH 16 Rev 6/95



ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 7-28-2000 **Physician** ISSA ISSAF 11:32pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Casey House 4c. County of Death Examiner 6001 Muncaster Mill Rd. Rockville Montgomery Birthplaca (Stata or Foraign Country) If Undar 24 Hrs. Data of Birth (Month, Day, Year) 5-25-45 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar **Funeral** Days Months Hours 1□M 20 F Yrs. 219-80-5616 55 Director Palestine Usual Residence of Decedent the Marytand 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show unotified at 1√2 Yas 2 No Directo Maryland Montgomery Takoma Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? thems 23a or ther must be r ъ 20912 Usa 1004 Houston Ave #1 Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Married b Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17 Fether's Nama (First Middle Last) 18. Mother's Nama (First, Middle, Maiden Surnama) permit. Pages 1 and 2 abouid be file Cogartment of Health and Mental Hy Important: if ham 27 is marched other any injury or other transmits event 9008. Be Mohamed Issa Warda Abdullah 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1004 Houston Ave #1, Takoma Park, Md. 20912 Mohamed Darwish-20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location · City or Town, Stata 1 Dourial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Ft. Lincoln Cemet. 7-31-2000 Brentwood, Md. 21. Signeture of Puneral Service Licenses 22. Nama and Addrass of Facility UNIVERSAL II MORTUARY INC. 411Kennedy St, N.W., Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause or each line. Approximate Interval Between Onsat and Deeth Physician /Medical Immediata Cause (Final GLIOBLASTOMA MULTIFOPME 13mos disease or condition resulting in death) Examiner Dua to (or as a consequenca of) Examiner ician and burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical phys. Dua to (or as a consequence of) 88 08n signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 ☐ Yas 2 ☐ No certificata 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Horna 5 Residence 6 Other (Specify) Hospice Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Atter 5 Pending investigation 1 Netural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, lactory, office building, atc. (Specify) 3 4 T Homicide To the Hospital
within 24 hours a
To the Funeral I
completely filled Hospital 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) edicai 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0037620 7-29-2000 and address of person who completed causa of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Mark S. Godec, M.D., Casey House, Rockville, Md. 20855

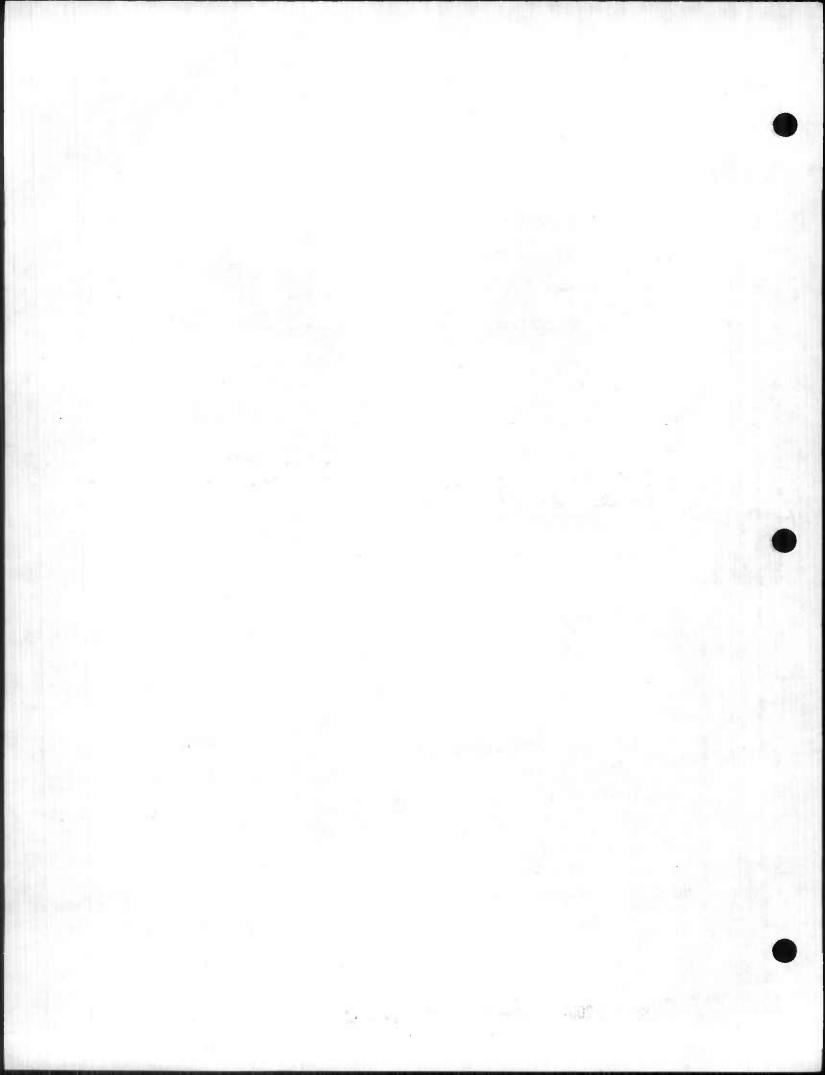
DHMH 16 Rev 6/95

Registrar

31. Data filed (Month, Day, Year)

JUL 3 1 2000

32. Registrar's Signature



00-4215-033 JERRY JOHNSON JVW

Funeral

Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Month Day Physician JERRY L. JOHNSON, JR. JULY 29, 2000 01:45 A.M. /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY If Under 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthptaca (Stata or Foreign Country) 1⊠M 2□ F 19 Months Days Hours Min 215-98-0197 Yrs. March 17,1981 Washington, D.C. Usuat Rasidence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Prince George's Upper Marlboro 1X Yas 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country?

20774

1 Yas 2K No Specify:

Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.)

U.S.A.

14. Rece - American Indian, Black, Whita, atc.

Approximata Intarval Batween Onsat and Death

1 OYas 2 □ No

COU1314

Specify: Black

16b. Kind of Business/Industry

28a-f show Directo must be notifie Funeral à

8 hams 23s 'natural', or Dearmit Pages 1 and 2 should be file Department of Health and Merial Mingottent: If hear 27 is mediated with injury or other 27 is mediated.

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760,

P.O. |

Division of Vital Records,

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician 188 8 page 2 should After this certificate Physician: 10 luneral or Attending after death.

I Director: Aft in by the fur within 24 hours a

1 ₩ Never Merried 2 Married 3 Widowed 4 Divorced Completed Non disaase or condition rasulting in daath) Examiner Physician/Medical à

12216 Wimbleton Street

12. Wes Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yas, Giva Yaer or Dates:

20a. Mathod of Disposition ~ ~ tmmediete Causa (Final Completed Be

23a. Part1. Entar tha disaase shock, or haert failura. Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initieted events rasulting in daath) Last 25. Was casa ratarred to medical

15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Elamantary/Secondary (0-12) College (1-4or 5+) Labor Private 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Jerry Lee Johnson Monica E. Brooks 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Monica Brooks Johnson/Mother | 12216 Wimbleton Street, Upper Marlboro, MD 20774 20b. Piace of Disposition (Nama of camatary, cramatory or other placa) Date 20c. Location - City or Town, State 08/04 1 ☑ Buriel 2 ☐ Crametion 3 ☐ Ramoval from Stata Suitland, Maryland Washington National Ceme. 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signetura of Funeral Sarvice Licensae J. B. JENKINS FUNERAL HOME Percentie 7474 Landover Road, Landover, Maryland 20785 , or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, jist only one cause on each line. Multiple Inpuries Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 No 26. Placa of Death (Chack only ona) Hospital: 1 ☐ Inpatient 2 NER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 X Yas 2 No 28b. Tima of tnjury 28a. Data of tnjury (Month, Day Year) 28c. tnjury at Work? 28d. Dascribe how injury occurred auto

27. Mannar of Death Certification: 5 Pending invastigation 1 Natural 1 Yas 2 PNo 7-29-00 assenger 2 Accidant 0050 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 T Homicida Robert Lewis oadvas 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and titia of certifier O.C.M.E. JULY 29,2000 30. Name end addrass of person who completed cause of death (ttam 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 rowler avid 31. Data filed (Month, Day, Year)

Registrar

pletely

AUG 0 2 2000

32 Registrar's Signature

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Year **Physician** Gloria Theresa Johnson 0018 2000 29 Jals /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6 eorge's hever If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under **Funeral** Months Days 1□ M 2□F Yrs. 578-52-3379 72 13, Director July Wash. Usuel Residence of Decedent 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 X Yas 2 No Director 28a-f District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner mart be n 2657 Stanton Road, S.E. #108 20020 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 b 1 Yes 2 No Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elemantery/Secondary (0-12) 12th College (1-4or 5+) Childhood Development Aide Private 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Charles Earl Butler Annie Mae Boykins 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) nt of Health a if flam 27 is or other tra-Cynthia P. Butler - Daughter 3604 Monte Carlo Pl., Forestville, MD 20b. Plece of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete Burial 2 Cremetion 3 Removel from Stete 8/3/2000 Lincoln Memorial Cem. Suitland, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility Stewart Funeral Home 21. Sign ture of Euneral Service Licen 4001 Benning Rd., N.E. Wash., D.C. 20019 nter the disaese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, if heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Ceuse (Finel disease or condition rasulting in daath) Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate causa. Entar Underlying Cause (Diseese or injury that inflieted events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical the Due to (or as e consequenca of) 080 signed by the at Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 → Winknown 1 Yes 2 No Division of Vital Records. Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy page 2 1 Yes -2 No 1 Yes 2 No this certificate or Attending Physician: funeral director, Be 25. Wes case raferred to medical exemiper? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Yes 2[] No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert Netural 5 Pending investigation within 24 hours after death. To the Funeral Diractor: A 1 Yes 2 No 2 T Accident 6 Could not be datarmined 3 [7] Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the causa(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Cartifier completely (Check only one) ŝ 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Do 30. Name and address of parson who complated cause of death (Item 23a) (Type, Print) Hospital 3001 SALVADOR 31. Dete filed (Month, Dey, Year) 32 Registrer's Signature AUG 0 1 2000

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Month Day Vear **Physician** 11/6 4b. City, Town, or Location of Death 2000 Margaret Alice Jernigan /Medical 10 4e Facility Nama (If not institution, give street and number) County of Deeth Examiner 9000 BriAncroft LANE Laurel rivce H Under 24 Hrs. 8. Data of Birth
Hours Min. May 1, 1915 If Under 1 Year 6. Sex 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 Months Pennsylvania 577-24-9058 85 Director Usual Rasidence of Decedant the Menyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Prince Georges Laure1 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Rems 23a 9000 Briar Croft Lane #121 20798 U.S.A. Funeral death 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, atc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 *natural*, or 1 Yes 2 No Specify: Specify: white by 3√√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within ment of Health end Mental Hyglene. mit II fem 27 is marked other than my or other traumatic event, the III Elementery/Secondary (0-12) College (1-4or 5+) Teller Bank 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be George Dean Mary un:obtainable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) James R. Rock / Son 62nd Ave. Berwyn Heights, MD 20746 20a. Mathod of Disposition

1 Burial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Othar (Specify) Lincoln Crematory August 1, 2000 Brentwood, MD Significant of Funaral Sarvice Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home B401 Bladensburg Rd. Brentwood, MD 20722 rebour iseusa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, liur. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Cardiovas enfar disaesa or condition resulting in daath) Examiner Examiner Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Disaase or Injury that initiated evants rasulting in daath) Last Due to (or es a consequence of): physicien s the buriel Box 68760, Physician/Medical Dua to (or as a consequence of): 93 nse use signed by the aid be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 has 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, Be 25. Was casa rafarred to medical 26. Place of Deeth (Check only one) axaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1-Natural 1 Yas 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be datamined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifiar completely (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 10 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) rive Cheverly MANGLAND 3001 Hospita 32. 31. Data filed (Month, Day, Year) Registrar's Signatura

DHMH 16 Ray 6/95

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

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Purpose bractor. After this certificate has been signed by the attending physician and placely filled in by the funeral director, page 2 should be detached for use as the burial-transit and placely filled in by the funeral director, page 2 should be detached for use as the burial-transit and placely filled in by the funeral director. To Be Completed by Physician/Medical Examiner	Im did re	a. Part. Entangued as a part of the control of the	conditions, immediate deriving or injury ints h) Lest set (Final into h) Lest	b. c. d. d. hops control getion not be hined graphysic Examine	ospital: 28a. Date (Mod 28e. Plac build Clan: To the tend man	Due Due Due Due Due Due Due Due	to (or as a control to (or	consequent	nce of): nce of): nce of): nce of): nce of): nce of): 200 M 21 A 200 22 A 290	ause giv	26. Plecenter: 4 No.	o of Deat	23b. Did 24a. We per 1 Check only 28d. Describe 28f. Location City or To	d tobecco d tobe	use confined No	tribute 1 3 Pro 24b. Was a cool of the coo	21811 Approximinterval B Onset an Interval B Onset an Interval B Oset	e(s)

S. UUA

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Jones, Pearl Roberta. ision of Vital Records, P.O. Box 68760, Baltimore, Maryland 2

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

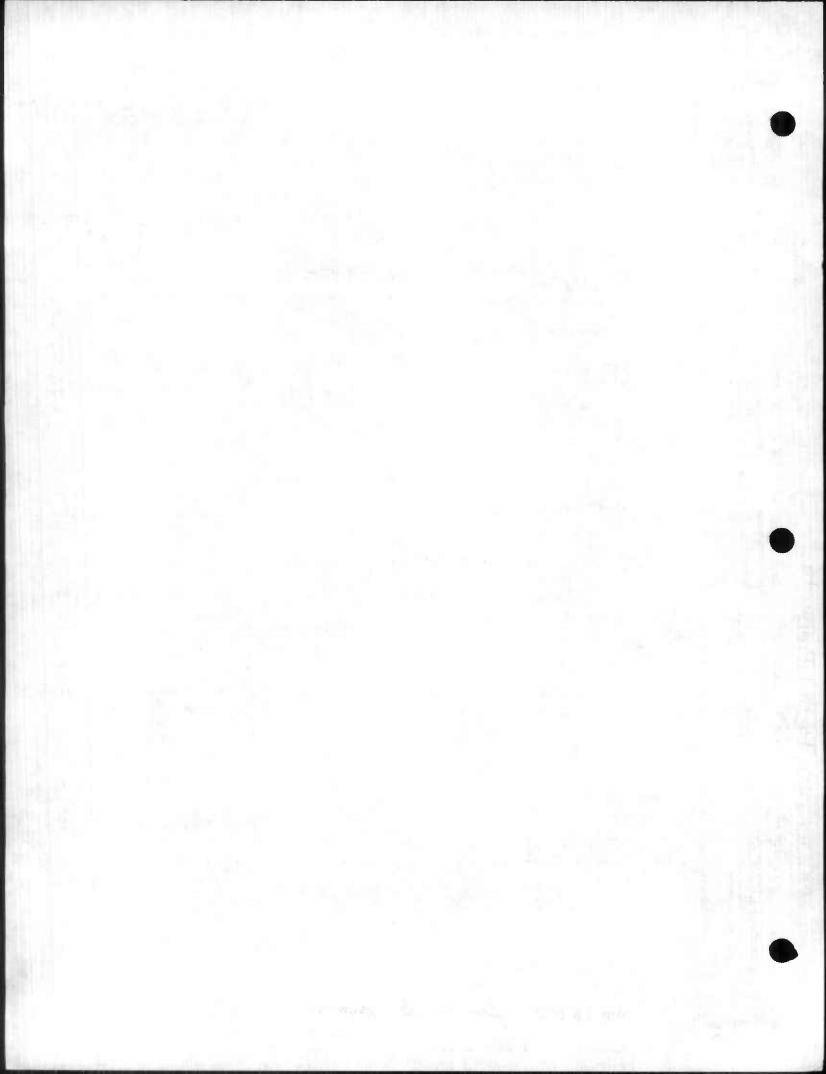
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2 5 | 1 0

			Ce	ertificate of i	Death	F	Reg. No.	20110
Physician	1. Decedent's Name (First, Middle, Le Pearl I	s) Roberta JON	IES			2. Date of Dea Month	Day	Year 6-35 pm
Examiner	4a Facility Name (If not institution, gh Washington Coun	Hagers		Was	hington			
Funeral Director	214-34-1103	Sex 7. Age (I	n yrs. last birthdey 63 Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Janunar	y 13,19	9. Birthplace (Stete or Foreign 37 Maryland
Meryland -f ahow	Usual Residence of Decedent 10a. State 10b. County Maryland Washing		Oc. City, Town or L Willia	ocation amsport				10d. inside City Limits 11€ Yes 2 □ No
h with the Me 23a or 28a-fa Bi Director	10e. Street and Number 12 South Conococ	heague Stre	et	10f. Zip Code 217	795	,	U.S.A	
1215-0020 within 72 hours after death with the Menyland ene. than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at simpleted by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 △ No If Yes, Give Year or Dates:	or in U,S. 13	Was Decedent of H It Yes, specify Cubs	lispanic Orlgin? (S an, Mexican, Puer Specity:	Specify Yes or No- to Rican, etc.)	14. Race Black Specify:	- American Indien, K, White, etc. white
nd 21215-0020 illydiene. il Hydiene. other than "natural", or vent, it a factor	15. Decedent's E (Specify only highest grant Elementary/Secondary (0-12) 0-10	ducation ade completed) College (1-4or 5+)	(Giv life.	edent's Usual Occup e kind of work done o DO NOT use retired nomemaker	ation during most of wo	rking	16b. Kind of Bush	siness/Industry wn home
Vlar Wente Mente Mente Mic •	17. Father's Name (First, Middle, Last	loyd Trumpo		- Comonator	18. Mother's Na	me (First, Middle, Mary Avi	Maiden Sumeme	9)
s 1 end 2 sho M Health and I Nem 27 is m other trauma	19a informant's Name/Relationship (Mrs. Cheryl Vins	on - daughte	er Post			Williams	sport, M	aryland 21795
Baltimore pemit. Pages 1 of Department of He important: If Nem eny Injury or oth page.	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lices)	Removal from State (y)	Rest Hav	emetory or other please 7 en Cemete 22. Name and Addre	ery ss of Facility	Minnich	Hagerst Funeral	own, Maryland Home , Maryland 2174
deeth certificate be executed deeth certificate be executed e attending physician and order use as the burial-transit sician/Medical Examiner	Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	b. HYPBRT DU C. INSULIN	e to (or es a conse EN CION e to (or as a conse	equence of): equence of):				24 horrs
P.O. hat the d by the detached	Part ii. Other significant conditions of	contributing to death but n	ot resulting in the	underlying cause giv	ren in Pert I.	23b. Did to	- 1/	tribute to the cause of death? 3 Probably 4 Unknown
Die 2 s b						24a. Was a perfor	an autopsy med?	24b. Wera autopsy findings available prior to completion of cause of death?
of Vital hystelen: This certificate his director, pe To Be Co	25. Was case referred to medical exeminer?	Hospitel: 1 Hopatient	2□ ER/Outpatio		er: 4 Nursing t	ath (Check only of Home 5 Resid	ne)	
Attanding or death. octor: After by the funa	27. Menner of Death 125 Natural 2 Accident 3 Suicide 4 Homicide	e One Diese of Injury	- At home, farm, s	M 1	yat k? Yes 2 □ No	28d. Describe h	er or Rural Route Number,	
To the Hospital or within 24 hours effer To the Funeral Dir completally filled in Medical Cert	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exer	nysician: To the best of m	my knowledge, dea amination end/or i			a, and due to the d	cause(s) and ma	
To the within 2 To the comple	29b. Signature and title of certifier Manufeu	ghay	J.	29c. Licens	e number 83 65		1	s (Month, Day, Year)
	30. Nama and address of person who MAN 2AA.	J. SHA	(Item 23a) (Type F1 368	Space Space	st. Hag	gerstaur	MD	21740.
State Registrar	31. Date filed (Month, Day, Year) AUG 0 8 20	32. Registrar's	Signeture	Spark	2	100		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** 10:30PM 2000 AUGUST BERNARD JOHNSON /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PERRY POINT (Month, Dey, Year) VA MARYLAND HEALTH CARE SYSTEM 7. Aga (In yrs. last birthday) 5. Social Security Number If Under 1 Yaar 6. Sex 9. Birthplace (Stele or Foreign **Funeral** Months 1 XM 2□ F Deys 70 Director JULY 1930 MARYLAND 218-26-5012 Usuel Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Director 28a-f MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of Whet Country? 10a Street and Number 10f. Zip Code 8 Norms 23a 89 COLLEGE CREEK TERRACE 21401 USA 14. Rece - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 12 Yas 2 ☐ No 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Merried ð If Yes, Give Yaar or Detes: 1950-53 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3. Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Cotlege (1-4or 5+) ANNAPOLIS CITY 12th MARKET FISHERMAN Baltimore, Maryland 17. Father's Neme (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 86 mportant: If less 27 is marked in y injury or 8 BERNARD JOHNSON SR. CATHERINE BROWN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) VIVIAN LAMBERT (COUSIN) 905 H. ROYAL ST. ANNAPOLIS, MD. 21401 HO 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stata 8urial 2 □ Cremation 3 □ Removal from Stete CROWNSVILLE, MD. MARYLAND VETERAN 8/4/00 21. Signeture of Funeral Sarvice Licensee 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. Zovry S, Seese MOOY83 821 WEST ST, ANNAPOLIS MD. 21.401

23a. Pen1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate interval Between Conset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) LUNG anknown Examiner Examiner sician and burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) the Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causa of death? P.O. 1 Yea 2 No 3 Probably 4 Defiknown signed b Records, A The lew requires 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yas 2 No 1 Yas 2 10 Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Wetural 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical \$ 29b. Signatura and titla of certified 29c. License number 29d. Data signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) PERRY ADINT, PERRY POINT MD 21902 BIONDO M. D. VAMHCS HOMAS 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar **AUG 0 4**

DHMH 16 Ray 6/95

JWBN

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State of Maryland / Department of Health and Mental Hygiene

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			Cei	rtificate of	Death		Reg. No.		
Physician /Medica	CHILDRING K.	JOHNSON				2. Dete of D Month Augus	t 6 ^{Dey} 20	0 0°	3. Time of Death
Examiner	An English himme (Mantheathrain mhin		lical	Center	Balt	i, or Location of Dea	th 4c. County	of Death	
Funeral Director	222-10-0344	x 7. Age (In yrs. 6		Months Deys		Min. 8. Date of B (Month, D Jan 2	6 1933	Coun	lace (State or Foreign try) W York
leath with the Maryland ne 23s or 28s-f show must be notified at	Usuel Residence of Decedent 10a. Stete 10b. County DE Kent		ny Town or Lo						0d. Inside City Limits 1 ☑ Yes 2 ☐ No
off) the Ma				10f. Zip Code	7		10g. Citizen of V		try?
The lot	11. Marital Stetus 1 Never Merried 2 Merried	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1997 Was Decedent of If Yes, specify Cub 1□ Yes 2⊠ No	Hispenic Origin en, Mexicen, I	n? (Specify Yes or N Puerto Rican, etc.)		e - America ek, White, o	
5-002 72 hours natural, o			16a. Dece	dent's Usuel Occu kind of work done DO NOT use retire	pation during most of	of working	16b. Kind of Be Depart	usiness/Inc	dustry Of
21215-0 ad within 72 ho rgiene. er then "natur it, the Medical.	Elementery/Secondery (0-12) 1 2	College (1-4or 5+)		ounting	Clerk		Correc	tion	
Maryland 21215-0020 d2 should be find within 72 hours all th and Mental Hygiene. The merited other then "naturel", or traumatic event, the Medical Exam To the Commission to the	17. Father's Name (First, Middle, Last)	ussell				Neme (First, Middle ence Lor		10)	
2 short and h	19e. Informent's Neme/Reletionship (T)					or Rural Route Num			Code)
	Clarence Johnso			25 Oal	Dr.	Smyrna,	DE. 19		wn. Steta
Mattimore, semil. Pages 1 ar Spartment of Hse mportant: If Isen: iny Injury or other mos.	1 ☐ Burial 2 ☐ Cremetion 3 🖾 4 ☐ Donation 5 ☐ Other (Specify,	Removel from State	ent Cr	emation		8-7-00	Smyrn	a, D	
Demit Depart Import Imp	21. Separated Funeral Service Ligaria	500 MOOS	TO -		ss of Fecility unera in St	1 Direct	tors, I		77
	shock, of heart fellure. List only of	licetions that caused the dee ne ceuse on each line.						199	Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	Respira	tory	Failure					4 days
		Pneumon	or as e consec	quenca of):					1 3
oxacuted named tal-transit	Sequentially list conditions.	b	or es e consec	quenca of):					4 days
ficate be executed ficate be executed by physician and as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						- 1	
in and in		Due to (or as e conseq	quence of):					
at the death of the attend steched for us.	Pert II. Other significant conditions co	ntributing to death but not re-	sulting in the u	indedvina cause a	iven in Part I	23b. Di	d tobacco use co	ntribute to	the cause of death?
T M D D D			John S To Co				Yes 2□No		bably 4 ZUnknown
COTO requir been s should							es an autopsy formed?	ev	ere autopsy findings alleble prior to mpletion of ceuse deeth?
The lew ate has page 2						10	Yes 2 No	10	Yes 2□ No
Clan: clan: entific ector.	25. Wes case referred to medical examiner?	Hospitel: .ar		100		of Deeth (Check only	one)		
His di	1 Tes 22-No	1 Enpatient 2L	28b. Time o	III SEI DON		ing Home 5 Re	sidence 8 Oth e how injury occur		y)
OIVISION OT or Attending Physiater death. Director: After this Jin by the funeral di	1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. Dete of Injury (Month, Dey Year)	Injury	M 1	Yes 2□N	o			
DIVISION C tall or Attending P ta after death. In Director: After t led in by the funers	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	ome, ferm, st	reet, factory, office			(Street and Numi own, State)	per or Hurs	i Houte Number,
Hospi 24 hou Funer stely fill		sician: To the best of my knowner: On the bests of examine and menner steted.							
To the within To the comple	29b. Signeture and title of certifier	Surgical	Resid		se number		29d. Dete signe		
ıλ	30. Name and address of person who c								
10	Eric A. Peck 31. Date filed (Month, Dey, Year)	4940 East				re, MD.	21224		
State Registrar		1 1	1.	. por	the state of the s				

0.10.	Phys.PGC 8-4		CI		Ce	rtificate	e of i	Death			Reg. No.		1.	15
sician	Decedent's Neme (First, M		oito V	.11						2. Dete of De Month	Dey	Yeer		of Death
edical	4a Facility Name (If not institu		nita K					th. City. Toy	wn. or Lo	July 2 pocation of Death		ty of Deeth	/:1	8 P.M.
iner	Southern Ma								into				orge'	S
ral	5. Sociel Security Number	6. Sex	200	. Age (In yrs.	last birthdey)	If Under Months	1 Year Deys	If Under:	24 Hrs. Min.	8. Date of Birt (Month, De	h v. Year)	9. Birth	place (State	e or Foreign
	242-05-2540		M 20 F	77	Yrs.					7/25/			Carol	
	Usual Residence of Decedent 10a. Stete 10b. Cou			10c. Cit	ty, Town or Lo	cation							10d. fnside	City Limits
lo	Md.		P.G.				Lan	ham						es 2 No
Director	10e. Street and Number	Real Line				10f. Zip	Code				10g. Citizen of	What Cou	ntry?	
al D	5408 Elmir	a Ave	nue					20706			U.	S.A.		
by runeral	11. Merital Stetus 1 □ Never Merried 2 □ Nover	Merried	2. Was Deced Armed Ford 1 Yes If Yes, Give Yeer or De	XXNo		Wes Deced			gin? (Spo , Puerto	ecify Yes or No Rican, etc.)		ace - Ameri ack, White,	can Indien, , etc. Black	
		dent's Educa			16e. Dece	dent's Usua	1 Occup	etion			16b. Kind of	Business/Ir	ndustry	
Be Completed	(Specify only high	phest grade		4or 5+)	(Give	kind of wor DO NOT us	rk done	during most d)	of work	ing				
Con	11th				Nur	se's i	Assi	stant			Nurs	ing	146	
Be	17. Fether's Neme (First, Mide									e (First, Middle,		m <i>e)</i>		
To	Joseph Wrig									abeth S	-			
	19e. Informent's Neme/Releti Clifton Spea									el Route Numberam, Md.	-	-	p Code)	
	20a. Method of Disposition			20b. F	Place of Dispo	sition (Nen	ne of		1	Dete	20c. Location	- City or T	own, Stete	
74	1 ☑ Buriel 2 ☐ Cremeti 4 ☐ Donetion 5 ☐ Othe		movel from S	lale	cemetery, cres orest				5.8/	5/00	Clint	on. M	d.	
	21. Signeture of Funeral Serv					2. Name an	d Addre	ss of Fecilit	V				-	
	Mar		n. (-	Prai		H.S.	Nash	ingto	n &	Sons Co	Wash	D C	20019	
Examiner	disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a.	ESRD-	DD Due to (d	or as e consec	quence of):					7	1 1 1 1 1 1 2		
lical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c.	нурох	Due to (c	epnalo									
Physician/Med		d.	Seizu	re Dis	order									
Iclar	Part II. Other significant con-	ditions contr	ibuting to don	ath but not con	udina ia tha u	a dadwina o	ausa sin	on in Bort I		225 Did	tobacco uee o	ontribute	to the caus	a of death?
	Part II. Other significant con	antions contr	ibuting to dea	un but not res	diting in the d	indenying c	ause giv	en in Perci			Yee 2 No			Unknown
Completed by										24e. Wes	en autopsy rmed?	a	Vere eutops vailable prid ompletion of death?	or to
Con										10	Yes 2 No	1	□Yas 2	.□ No
To Be	25. Was case referred to med examiner? 1 Yes 2 No		spitel:	patient 2 E	ER/Outpetie	nt 3E DC	Oth	or.		h (Check only o		ther (Spec	ify)	
atlon:	Z LI Accident	estigetion	28e. Dete of (Month	Injury , Dey Year)	28b. Time o Injury	M 2	8c. Injur Wor 1 🗆	yet k? Yes 2⊡		28d. Describe	how injury occ	urred		
edical Certification:	3 Suicide 6 Co 4 Homicide del	ermined	28e. Plece o building	of Injury - At h g, etc. (Specii	ome, ferm, st	reet, factory	, office			28f. Location (City or To	Street end Nur wn, Stete)	nber or Rui	ral Route N	umber,
adical				sis of examine						and due to the red et the time,				e(s)
Medical Certification: To Be Com	129b. Signature and title of Co-	HE CO	Br	31		290		e number			29d. Dete sign	ned (Month	Dey, Year	r)
	1	1	1				D	00463	74		7/2	29/1	200F	
	30. Name and eddress of per-								- 1	2,Washi		-		



		State of Marylar		ment of F icate of			giene U (Reg. No.	1 2	6114
Physician /Medical	Decedent's Name (First, Middle, La Cliffo		Kobi			2. Date of De Month August	Day	OOO	3. Time of Death 3:30AM
Examiner	4a Facility Name (If not institution, given 13816 Misso				6b. City, Town, or Li Brandywi				eorge's
Funeral Director		Sex 7. Age (In yrs 78		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da OCt. 3	, 1921	9. Birthpl Cappt Indi	ace (State or Foreign try) ana
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atter death with the Maryla or Items 23s or 28s-I sho unions must be notified at I Funeral Director	Maryland Prince G 10e. Street and Number 13816 Missouri A		Brandy	wine of. Zip Code 2061	3		10g. Citizen of W	/hat Count	try?
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(10)	30. Name and eddress of person who of	ompleted cause of death (Ite	m 23a) (Type, Prin	(t)	Cherry	ande A	11 2	785
State Registrar	31. Date filed (Month, Day, Year)	32, Registrar's Sign	nature A	land.		11	9.	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

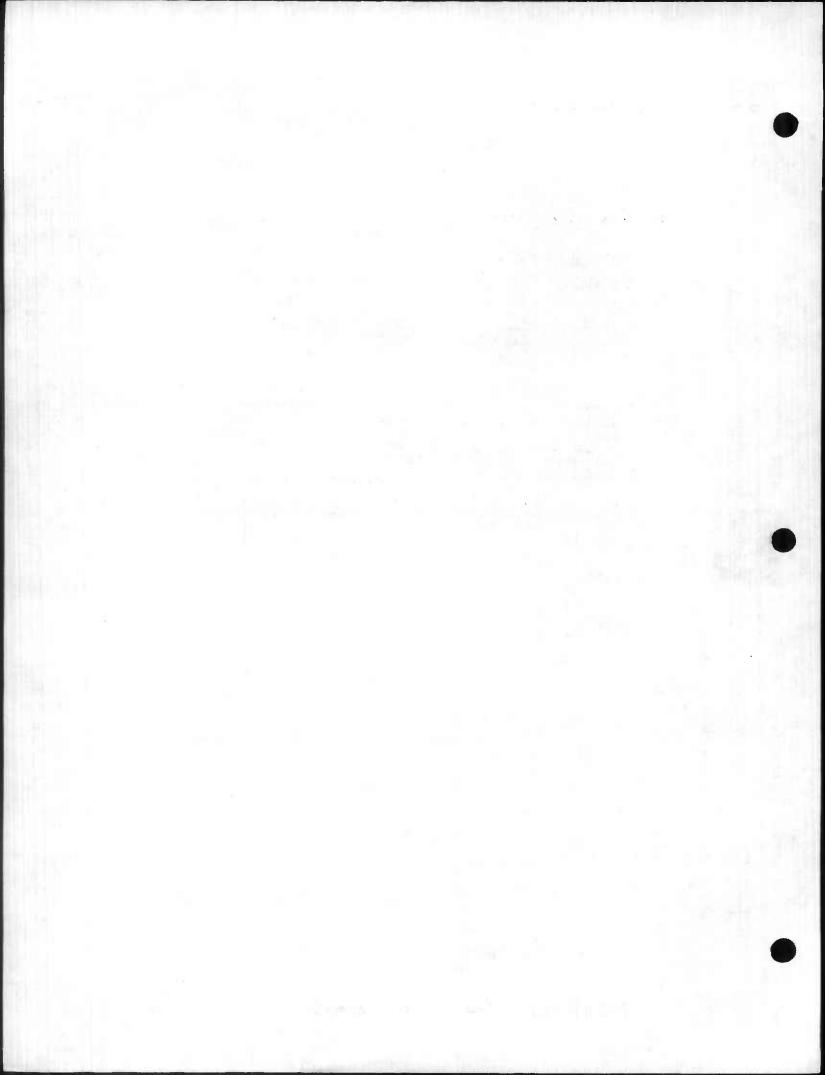
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:15 AM DOROTHY LORRAINE KLINE August 2000 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 19142 Olde Waterford Road Washington County Hagerstown Hunder 24 Hrs. 8. Dete of Birth Hours Min. (Month Dey, Year)
Jan 23, 1944 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Yeer **Funeral** Months Deys 1□M 2☑F 56 Director 214-42-0832 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Ikem 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumstic event, in a Medical Examinar must be notified at 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Director Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19142 Olde Waterford Road 21742 USA Funeral 12. Wea Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Residence Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) William Jeff Frederick Virginia M. Cook 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21742 19e. Informent's Neme/Reletionship (Type, Print) 19142 Olde Waterford Road, Hagerstown, Maryland Ronald E. Kline, Sr., Husband 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐Cremetion 3 ☐Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or Smithsburg Crematory Aug. 7 Smithsburg, Maryland 21. Signeture of Funerel Service Licensee 22. Bouglas SAN FEW Pery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se cause of each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel lance diseese or condition resulting in death) 5 yrars Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or es e consequence ot): been signed by the atte should be detached for P.0. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 10 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No edical Certification: To After this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director; 3 ☐ Sulcide 6 Could not be 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steled. 29e. Certifier completely (Check only one) ş 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 8.7.00 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) McCormack Dagerhun Mo 21792 medical Campus Ed. 11110 31. Dete filed (Month, Dey, Year) AUG 0 8 2000 32. Registrer's Signeture

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene

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		Kennetl	h Nichola	s Lodow	ski				Pau	la Anr	ne K	eane			
-	19a. Informent's Na	ame/Relationship	(Type, Print)		19b. Mailing	Address	(Street	and Numb	er or Rur	al Route Nun	nber, Cit	ty or Town,	State, Zip	Code)	
	Theresa	A. Keane,	/ Wife		2513 I	Howan	rd G	rove	Road	David	lson	ville	, MD	2103	35
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	shock, or hea	irt failure. List only	one cause on each	h line.	00 1101 011101			9, 0001100						Interval	Between and Death
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aminer	4a Facility Nama (If not institution 1239 SOUTHVIE		number)			4			ocation of Deat			GEORGE'S
eral ctor	5. Social Sacurity Number 220 90 5765	6. Sex 1 → M 2 □	7. Aga (In yrs. 22	last birthday) Yrs.	If Under 1 Months I	Yaar Days	If Undar 2 Hours		8. Data of Bir (Month, Da April	th ly. Year)	9. Birth	plece (Steta or Foraign ntry) ington D.C
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completely filled in Medical Cert	29a. Certifier 1 Certifyi (Check only one) 1 Certifyi	Examiner: On th	tha best of my kno a basis of axamine nannar statad.	owledge, daat etion and/or In	h occurred at vastigetion, in	tha tir	na, deta end pinlon, deetl	plece, h occur	end due to the red at the tima,	date and pleca	annar as , and due	stated to the ceuse(s)
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DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

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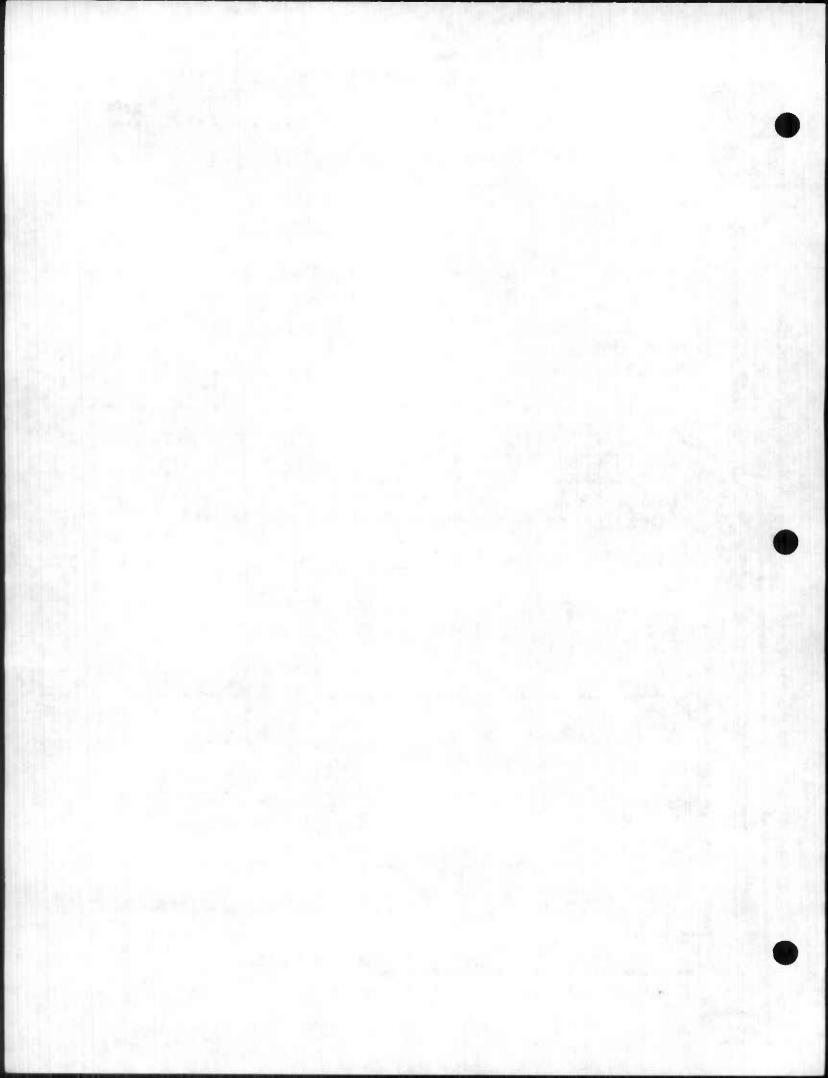
32 Registrar's Signatura

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 8 8:15 AM 2000 ELIZABETH S. LILLEY /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8320 Hudson Drive La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F 577-07-2787 88 Yes Director January Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or Name 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8320 Hudson Drive 20646 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White À 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene other than Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked of Pages 1 and 2 should be William H. Black Alda M. Ketcham and it 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health reportant: If Nem 27 8320 Hudson Drive La Plata, MD 20646 Donald Lilley/Son 20a. Method of Disposition

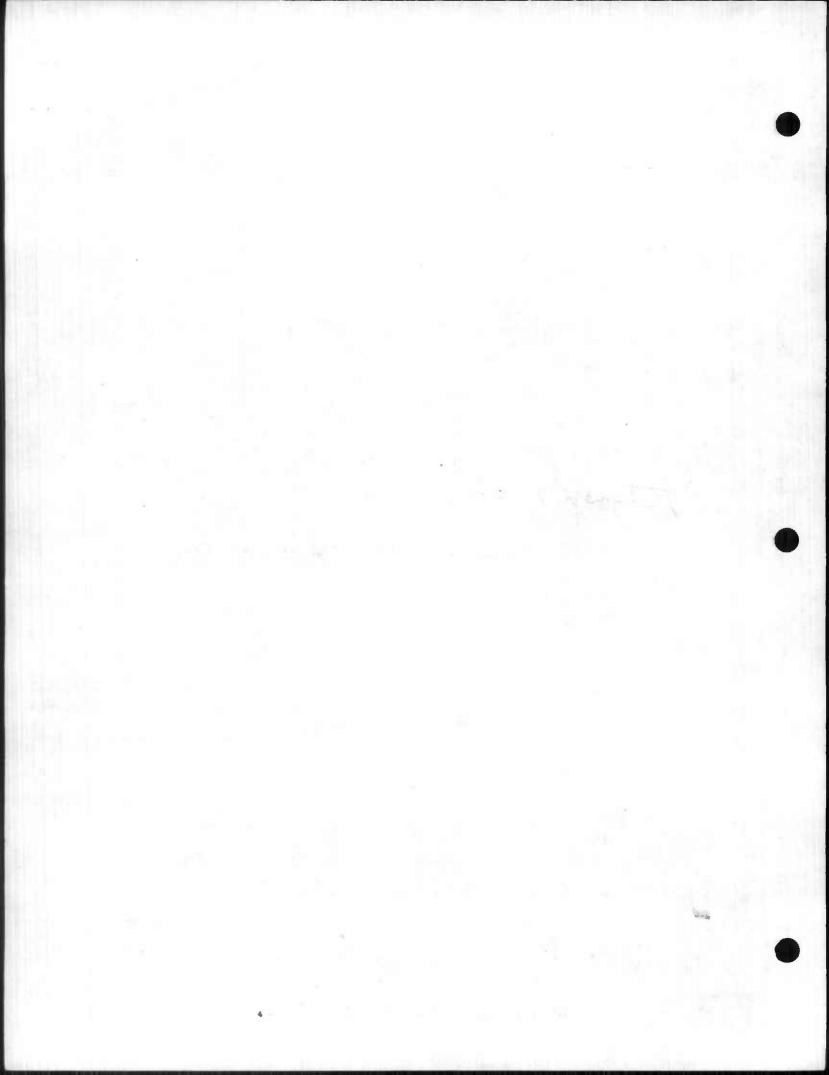
1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cametery, crematory or other placa) Date Fort Lincoln Cemetery8/9/00 Brentwood, MD. any Injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00945 AREHART-ECHOLS FUNERAL HOME, P.A. Navel C. Cehl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 567 LA PLATA MD. 20646 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical tradonetria greinong year Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, as the Due to (or as a consequence of) USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco was contributa to the cause of death? 2 No 3 Probably 4 Unknown been signed by 1 Yes Be Completed by 90 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 should 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 1 Yes 2 No al or Attending Physician: The safer death.

In Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) rilled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated. 29a Cartifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0033426 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) III LAGRANGE AVE P.O. BOX 2665 LAPLATA, MD JENKINS M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 0 9 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Helen Louise Lewis August 9 2000 4:00 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year)
Tan. 19,1914 426 N. Potomac St. Washington If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 219-12-1636 D 10 M 20 F 86 Yrs Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 NYes 2 No Director Md. Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 426 N. Potomac St. 21740 U.S.A. Funeral filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mentel Hyglene Important: if frem 27 ie marked other tru eny injury or other treumatic event, trea Home Homemaker 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl Brown Ida Mae Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David R. Lewis (Son) 426 N. Potomac St. Hagerstown. Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 11, 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specif Bethel Cemetery Foxville, Md. 1. Signature of Funeral Service Lie 22, Name end Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 2 No 3 Probably 4 Unknown Records, P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturat deeth. 1 Yes 2 No 2 Accident within 24 hours after deeth To the Funeral Director: completely filled in by the 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

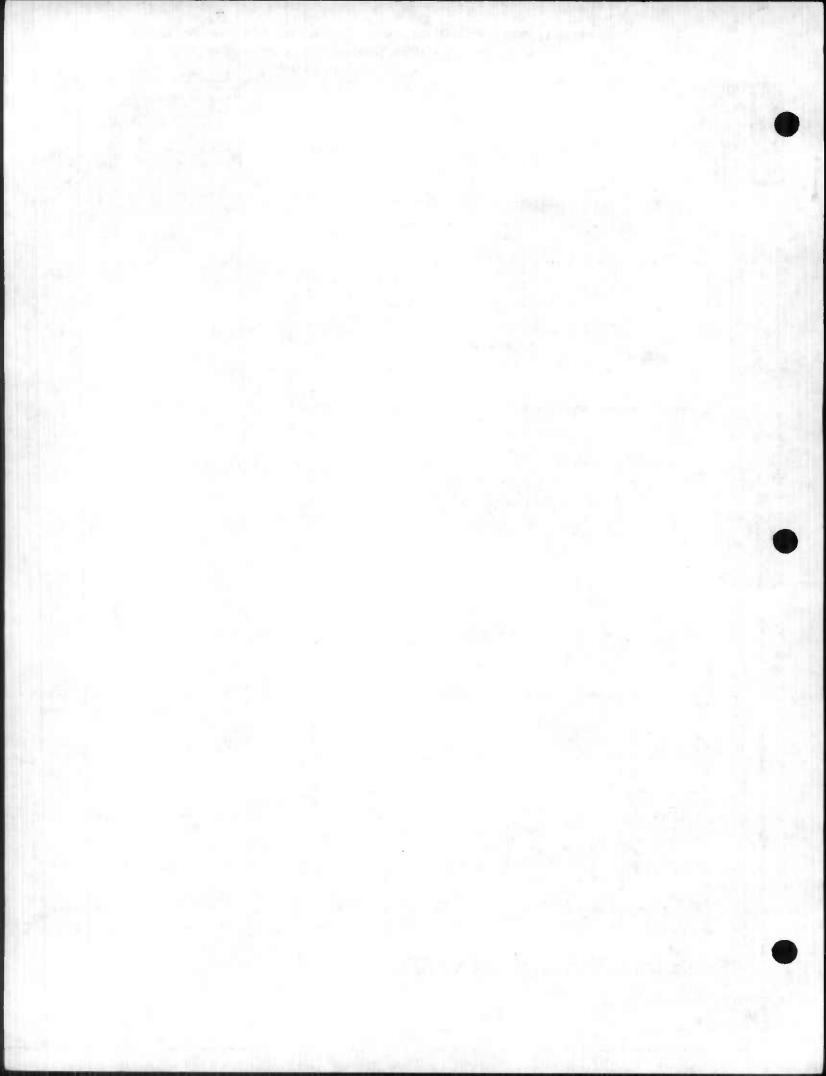
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier ŝ 29b. Signalund and title of certifie 29c. Ligense number 29d. Date signed (Month, Day, Year) 2 to completed cause of death (Item 23a) (Type, Print) Houserstown, 823 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2900 AUG 1 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death **Physician** HILDA LANKFORD 26, 2000 July 5:00 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park Anne Arundel 513 Grandin Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1□ M 20 F Months Hours 212-34-6387 65 Yrs. Director 1935 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 No Director 10f. Zip Code 21146 10e. Street and Number 10g. Citizen of What Country? 6 513 Grandin Avenue USA permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Health and Mentel Hygiene. Important: if them 27 is marked other than "netural!. A page 10 page. 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 전 No If Yes, Give Year or Dates: 11. Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, Whita, atc. 1 Never Married 22 Merned 1 Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Gabriel Lukenich Minnie Lang 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Lankford/ son 513 Grandin Avenue, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) July 27 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel Imm Metro Crematory 2000 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungeal Service Lider 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 ion that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, cause on each lina. Approximate Intervel Between Onset and Death Physician /Medical de Cause (Final SQUAMOUS CANUMOMA of SICIA disease or condition in death Due to (or as a consequence of): Examine Due to (or es a consequence of). physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of deeth? 1 Yaa 2 No 3 Probably 4 ☐ Unknown COPD p Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) To Other: 4 Nursing Homa 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, data end place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) Maria 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore, MD 225 Cheene ROBERT HADDAD shieet 31. Date filed (Month, Day, Year) State 7/27/JUL 3 1 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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	neral ector	5. Social Security Number 6 264-36-9811	Sex 1 M 2 F 7. Ag	e (In yrs. last birthdi 68 Yrs	Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of Birth (Month, Dey, May 12	Year) 1932	Coun	lace (State or Foreign try) Lin, GA		
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d be lette	To Be	Frank McClendo				11/1/19	ie C			T i				
Shoul should	-	19a. Informent's Name/Relationship		19b. M	eiling Address	(Street	end Numb	er or Rure	al Route Number	City or Town,	Stete, Zip	Code)		
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Box eeth cert	etached for use	D. All Other Jan Warner and Helica		A sea sine interests and	a considerate de disconsiderate		De Al		Did as		mênîhu de ê	o the sauce of death?		
0 8	be detached i	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying o	ause gr	ven in Per	l.	100	bebly 4 Unknown				
that	be det								Yesy	●● 2□ No	001110			
Corc	should							_	24a. Was e perior	n autopsy med?	av	ere autopsy findings elleble prior to empletion of cause death?		
	page 2								1 U Y	es al No	1.1	□Yes 2□No		
	0 O	25. Was case referred to medical					26. Piac	e of Deatl	n (Check only or					
	0 0	examiner?	Hospitel:	ent 2 ER/Outpe	tient 3 D	Ot AC	hor	ursing Ho	1.1	ence 6 Oth	er (Specia	(y)		
Attending Physics of death.		27. Manner of Death 1 Designaria 5 Pending 2 Accident Investiget	28a. Dete of Inju (Month, De	ry Year) 28b. Tim tnju	e of S	28c. Inju Wo 1 [ry at ork?] Yes 2 □		28d. Describe h	ow injury occur	red			
Division or Attending after death.	led in by the funeral Certification:	3 Suicide 6 Could not determine	d 289. Piece of inj	ury - At home, farm, c. (Specify)	street, fector	y, office			28f. Location (S City or Town	treet and Numb n, Stete)	er or Run	el Route Number,		
Hospita 4 hours	pletely filleced		Physician: To the best of aminer: On the basis of manner sto	examination and/o										
To the within 2	Comp	29b. Signature and time of bartiller			29	c. Licen	se number	55	2	9d. Date signs	Bull	Day, Year)		
(1	0/	30. Neme and eddress of person wh	completed cause of d	leath (Item 23a) (Ty	pe, Print)	C	Quit	tos	Sur.	,	· ·			
R	State egistrar	31. Dete filed (Month, Dey, Year) AUG 0 2 2000	2. Registr	ar's Signature	Loon	4			-					

See I was a property

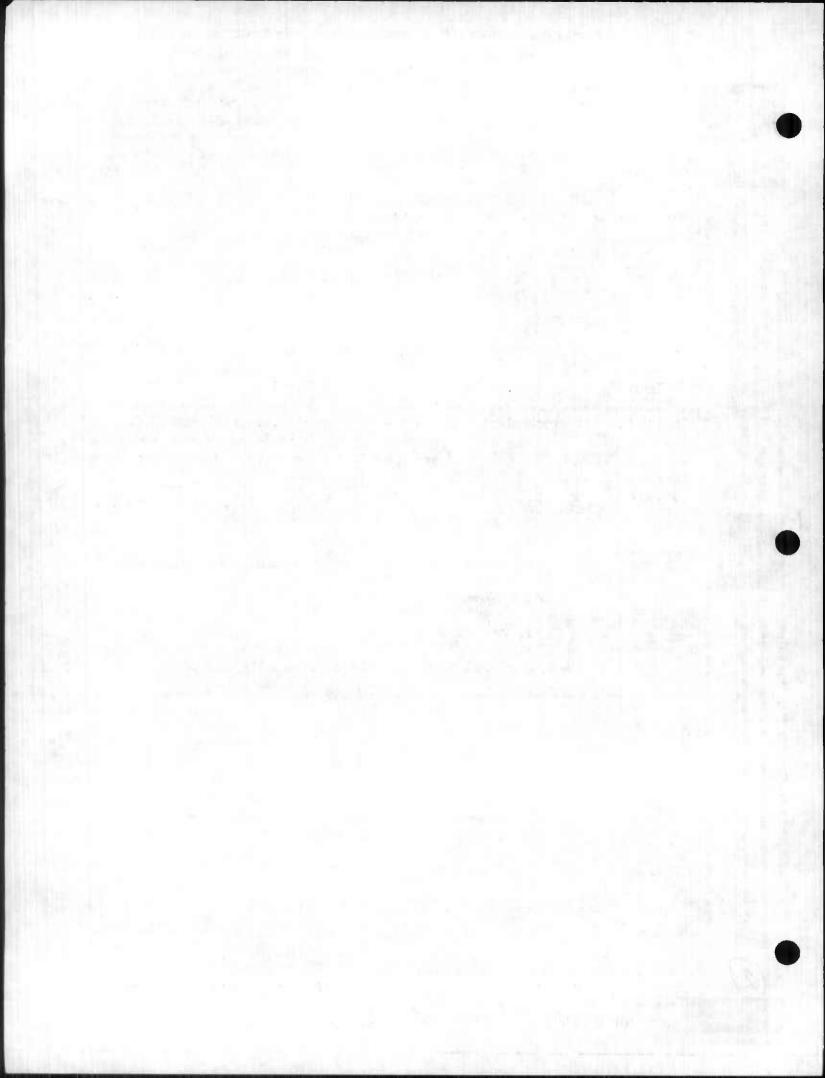
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State of Maryland / Department of Health and Mental Hygiene

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								Cer	titica	te ot	Death			Reg. No	٥.		
П		_	. Decedent's Name (First, Midd	e, Last)	Maria	100		All S					2. Data of De Month		ıv	Vaer	3. Tima of Death
	Physician	_	0zel1	M	arie		Mc Comb	S					July	22,	¹ 200	0	7:50 P.M.
	/Medical Examiner	4.	Facility Neme (If not institution	n, giva stre	et and n	um <i>ber)</i>					4b. City, To	wn, or Lo	Location of Death 4c. County of Death				
	Examine	п	Washington Adventist Hospital						Tak	coma	Park		Mont	gomer	'n		
	Funeral	5.	Social Security Number	6. Sex			(In yrs. last bi	rthdey)		r 1 Year			8. Date of Bi	rth		9. Birthpl	lace (Stete or Foreign
ш	Director		242-38-7249	1□ M	2XD F		75	Yrs.	Montha	Deys	Hours	Min.	8. Date of Bir Month, Da May 2	y, Year	925	Nort	Th Carolina
Ь		-	Isual Residence of Decedent							1		1					
	land	10	0a. State 10b. County				10c. City, Tov	vn or Loc	cation		- 17					10	0d. Inside City Limits
	Mary 10		District of Columbia Washington														1 XYas 2 No
	or 28e-f s	1	0a, Street and Number			-			-	p Code	-		10g. Citizen of What Country?				
	\$ 9 B		6304 - 5th S	treet	. N.	W.			1000		011					Stat	
	after death with the Manylar or Nems 23a or 28a-f show trings the practited at / Funeral Director		11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sc								noihi Van or Ni			e - America			
	5 4 5			12.	Armed F	Forces?	ei iii U,S.	13. V	Yes, spe	ecify Cut	an, Mexica	n, Puarto	Rican, atc.)			k, Whita,	
20	by F		\times \									Specify	B1	lack			
21215-0020	O F					Datas:	140			-10				405 1	Control Di		
5	be filed within 72 ho that Hygiene. Id other than "naturn event, the Medical Be Completed		15. Deceder (Specify only higha	st grada co	on m <i>pleted</i>	1)	168	(Give I	ent's Usu	ork done	during mos	st of work	ing	100. F	Vind or bu	siness/Ind	ustry
12	F F F F		Elementery/Secondery (0-12)		College	(1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired) Food Service Worker					D.C. Governme				ment
	filed withis Hygiene. other then ent, if a Head of the Hygiene of the		12th grade 7. Fathar's Name (First, Middla,	1				1000	1 261	VIC			e (First, Middle	A do into	Cumam	01	
ž	D S S S S S S S S S S S S S S S S S S S	6		LHSI)	Ma	Comb	c					rgie	e (Filst, Middle		lawls	9)	
yie	should be nd Mentel marked o umatic ev	-	Clauzell														
Maryland	N 0 0 0	1	9a. Informant's Name/Relations	ship (Type,	Print) (daug	hter)19	b. Meilin	g Addres	s (Stree	t and Numb	er or Rur	al Route Numb	er, City	or Town,	Stete, Zip	Code)
	1 and 1 Health em 27 other tra		Bonita M. West	Broc	kend	erry							;Washi				
ore	of He	21	Oa. Method of Disposition	2 CD	arral frame	Chala	20b. Place of cemere	of Dispos ery, crem	sition (Ne netory or	me of other ple	ce) Ju	ly 29	2000			City or To	
Ĕ	Pages nent of I int: If He iny or or		1								ry Adelphi, Maryland						
Baitimore,	In property	2	1. Signature of Funeral Service	Licensee	/	31		22.	Nama e	nd Addr	ess of Fecili	ity					_ /- /- /- /- /- /- /- /- /- /- /- /- /-
Ö	De la		V2011	4		>	- 11	R.	N. F	dort	on Con	npany	Morti	clan	ISS I	nc.	20011
1		+	600 Kennedy Street, N.W.: Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest. Approximate														
		1	23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death														
	Physician /Medical																
	Examiner	d	mmediate Cause (Final lisease or condition esulting in deeth)	a 7	256	PIKAT	Tory F	AILL	46	3	101	1255	ive Rt.	Plan	val.	EFRA	· land
			obstang an doorny			D	ue to (or es a	consequ	uence of):							
	b is is			m h	9221	HEin	10:15	Di	SEAS	E-						i	
	n and ial-transit	9	sequentially list conditions,	b. ALTHEIMERS DISEASE Due to (or es e consequence of):													
0,	de ex		sequentielly list conditions, any, leading to immediate ausa. Enter Underlying ause (Disease or injury	1 . 1	4	of	HEART.	1.5									
68760,	eath certificate be executed attending physician and lor use as the bunal-transit clan/Medical Examir	ti r	hat initieted events esulting in deeth) Last	6.2		D	ue to (or as a	consequ	uence of)	:						9 -	
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Вох	andi BITA			d.//	X OI		6174217	77. 6		7 6	- wie			feel	0000		
	0 0 0	P	art II. Other significant condition	ons contrib	uting to	death but	nol resulting	in the un	nderlying	cause g	iven in Part	1.	23b. Did	tobacc	o uss co	ntribute to	the causs of death?
P.0	by the																bably 4 Unknown
	signed d be def															-2-1	
dis	requires that the seen signed by the hould be detach etech by Physe												24a. We		opsy	24b. We	ere autopsy findings
00	been s should	_											peri	ormed?		CO	allable prior to mpletion of causa death?
3e	has pe 2																
-	Date h.												10	Yes	No	16]Yes 2□ No
/#	certificate har rector, page	2	5. Was casa referred to medica axaminer?		- 20 - 1 -					10		e of Dee	th (Check only	one)			
of Vital Records,	S G G		1 Yes 2 No	Hosp	12	Inpatient		utpetient	1 3□ 0	0/		ursing Ho	ome 5 Res				v)
	ding Ph. After th funeral	2	7. Menner of Death 1 Netural 5 ☐ Pendir		28e. Dete (Mo	e of Injury onth, Dey	Yeer) 28b.	Time of Injury		28c. Inju	ork?		28d. Describe	how inj	ury occur	red	
Division	or Attending I ifter death. Director: After in by the fune ertification		2 ☐ Accident investi	igation					М	1 [Yes 2	No .					
5	after death Director: d in by the		3 Suicide 6 Could 4 Homicide determ		28e. Pled	ce of tnjur	y - At home, f	erm, stre	et, fecto	ry, office)		28f. Location City or To	(Street a	ind Numb te)	er or Rura	I Route Number,
Ö	Lal or Attending P is after death. In Director: After the ad in by the funera Certification:						(,										
													end due to the				
	he Hospin 24 hound he Funer pletely fill edical		one) 2 Medicat	EXEMPLE:		basis of e		nevor inv	estigatio	ii, in my	opinion, de	etti occur	red at the time	, uete ar	и расе,	and due to	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
	Withir Comp		9b. Signature and title of pertific	er				1	29	c. Licen	se number			29d. D	ata signe	d (Month,	Day, Year)
			Laina	Λ'	M	0				Dan	5371	19.			7/2	3/20	20
	(2)	2	Name and address of person				th (tem 23a)	(Type I	Print\	900					, ,	- 1	
	(2)	3	A T . 1		HAV		306			IIV	110	d	Rod	ie 1	mn	207	116
	2111	3	1. Date filed (Month, Dey, Year)				's Signatura	0 111					500			70,	. 0
	State Registrar	,	JUL 3 1		32.	2-selv		4	1	ark.	,						
	negistiai		JOT 9 T	2000	1/4	7	1		July 1	- CAGA							

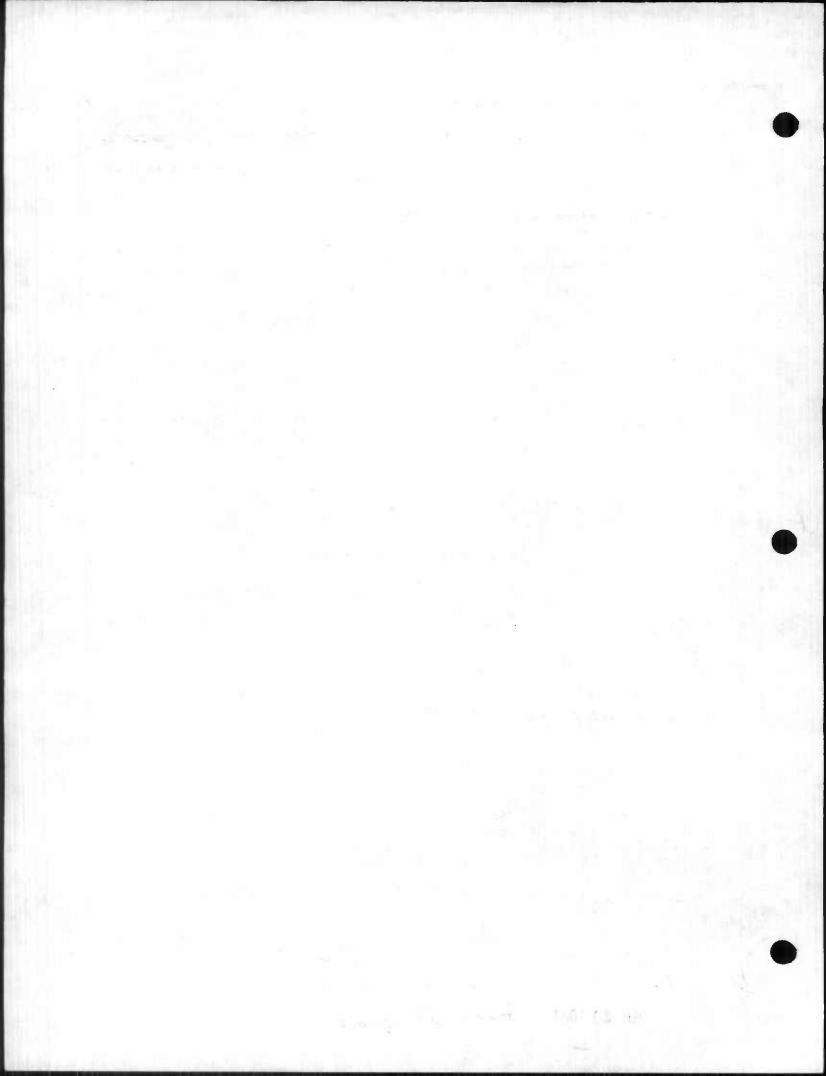


State of Maryland / Department of Health and Mental Hygiene 00 26126

			Ce	ertificate of	Death		Reg. No.	
Physician	1. Decedent's Nama (First, Middla, L.					2. Data of D Month	oath	3. Tima of Death
/Medical		Brown McDona	Id		4h Ch. T	July	25 Day 2000	6:24 P.M
Examiner	4a Facility Nama (If not institution, gi Washington Adve	ntist Hospita		N. W. Harden & V. and	Takoma		Mont	tgomery
Funeral Director	237-26-1144	Sex 7. Age (In)	yrs. last birthday Yrs.	Months Days		n. April	10,1914	9. Birthpiaca (State or Foreign Country) North Carolina
within 72 hours after death with the Maryland and ana. The Hadrell Englisher mast be notified at the Hadrell Englisher mast be notified at the Majoret Englished By Funeral Director.	Usual Rasidence of Decedent 10a. Stata 10b. County Maryland Prince	Georges 10c.	City, Town or L	ocation ege Park				10d. Insida City Limits 1)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
3a or 28 st be not	10e. Street and Number 4711 Berwyn Hous	e Road, Apt.	420	10f. Zip Coda 20	740		10g. Citizan of V United	What Country? States
al, or heme 23a or 28a-f above Exercise must be northed at by Funeral Director	11. Marital Status 12. Was Decedent Evar in U, Armed Forces? 1 Nevar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U, Armed Forces? 1 Yas 2 No If Yas, Give Yaar or Datas:			Was Decedent of If Yas, specify Cub		(Specify Yas or Nerto Rican, atc.)	o- 14. Rac Blac Specify	e - American Indian, ok, Whita, etc. Black
ygiena. ygiena. 'r. tr. Prodes Ex.	15. Decedent's E (Specify only highast gi Elementery/Secondary (0-12)		16a. Dece (Giv. lifa.	edant's Usual Occu e kind of work dona DO NOT usa retire COOK	pation during most of w d)	rorking		Services
avant, Be Cc	8th grade 17. Father's Nama (First, Middla, Last) James Brown			COOK		ama (First, Middle ence	a, Maidan Suman	
27 is mary r traum	19a. Informant's Name/Relationship J. Calvin Adams	(nephew)	5159		Hill Ro	ad, Colu		State, Zip Code) aryland 21045
Department of Haalth mportant: If Ham 27 any injury or other tr ange.	20a. Method of Disposition 1			position (Nama of amatory or other place) _incoln C		29,2000		city or Town, Stale
Department Important: I any injury o	21. Signature of Funaral Sarvice Local	(DI)		R. N. Ho 600 Kenn	rton Com edy Stre	et.N.W.:	Washingt	Inc. con.D.C. 20011
hysician /Medical xaminer	23a. Part1. Entar tha diseasa, or cor shock, or heart failura. List only Immediata Causa (Final diseasa or condition resulting in death)	a. RESPIRA	HURY	FAIL	UKE			Approximeta Interval Between Onsat and Death Four WEEKS
e attending physician and bod for use as the burlat-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last	Lug Duat	O (or as a consecutive of consecutiv	HSE.	0BSTR	ય લા પ્રક		
d by the attend etached for us Physician/	Part II. Other significant conditions	contributing to death but not	rasulting In tha	undarlying causa g	iven in Part I.	23b. Die	tobacco une co	ntribute to the cause of death?
	CORONARY		1)	1 Yes 2 No 3 Probably				
should should						24a. Wa	s an autopsy formed?	24b. Wara autopsy findings available prior to complation of causa of death?
certificate has been signed by the rector, page 2 should be detached. Be Completed by Physical Physic							Yas 2 No	1 ☐ Yas 2 ☐ No.
	25. Was casa refarred to medicat axaminar?	Hospital:	2 ER/Outpatio	ent 3 DOA O	thor	Home 5 Re	ona) sidance 6 □Oth	ner (Snecity)
# F	27. Mannar of Death 1 Naturel 5 Pending 2 Accident invastigetic	28e. Data of Injury (Month, Day Yea	ury at ork?		how injury occur			
rs after death. al Director: After ted in by the funera Certification:	3 Suicide 6 Could not 4 Homicide detarmined		28f. Location City or To	(Street and Numi own, Stata)	ber or Rural Routa Number,			
Funer Funer Testy fill	29a. Certifier 12 Certifying P (Check only one)	hysician: To the best of my miner: On the basis of exer and manner stated.	knowladga, daa nnation and/or i	th occurred at tha t nvastigation, in my	ima, data and ple opinion, daath oc	ce, end dua to the curred at tha time	e causa(s) and man, date and placa,	anner as stated. and dua to the causa(s)
within 2 To the comple	29b. Signatura and this of continu		j. 50	29c. Lican	sa number		_	d (Month, Day, Year)
	1/ Xum				22910		July 2	57/2000
1)	30. Name and address of person who ASIF S. QAD	completed causa of death (Item 23a) (Type	House	20, (College	e park	c mo 20740
State Registrar	31. Data filed (Month, Day, Year) JUL 3 1 2000	33. Registrar's Si	ignatura	done	,			

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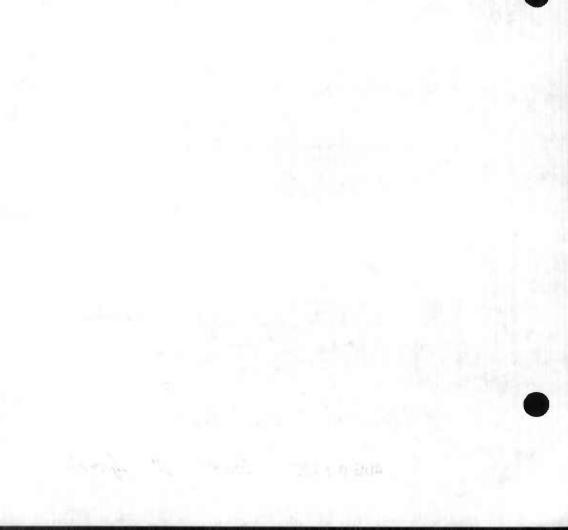
BILLALY	Matthews 1. Decedant's Nama (First, M	iddla, Last)		Cent	ificate of	Death	2. Date of De	Reg. No.		3. Time of Death
Physician	James		thews				Month	Day	Year	
/Medical	4a Facility Name (If not institu	ution, give street end nu	mber)			4b. City, Town, or Li	July ocation of Deat			1552 pm
Examiner	4400 Shell S					Capitol H	eights	Prince	e Geo	rge's
Funeral Director	5. Social Security Number 579-70-0617	6. Sex 1 € M 2 □ F	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Bir (Month, Da Jan. I	8, 1953	9. Birthpl Count Was	dace (State or Foreign (ny) hington, D.
	Usual Residence of Deceden 10a. State 10b. Cou		10c. City	y. Town or Loca	ation				10	0d. Inside City Limits
28s-f show notified at rector			W	ashingt	on, D.C	. 42.56				1∆ Yas 2□No
iner must be notified Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	Vhat Coun	try?
ner must b	3739 D. Stree	t, S.E. #10	1		20	019		United	Stat	es
ine.	11. Marifal Status	Armed Fo		S. 13. W	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puarto	ecify Yes or No Rican, etc.)	14. Race Blac	- Amarica k, White,	
by Fu	1 Never Married 2 □ I	H Vac Gi	2 No		☐Yes 21 No	Specity:		Specity	Bla	ck
Pe	15. Dece	dent's Education	4103.	16a. Decede	nt's Usual Occup	pation		16b. Kind of Bu	ainess/Ind	lustry
Be Completed	(Specify only hij	phest grade completed) College (1-4or 5+)			pation during most of work d)	ing			
Сотр	11			ETe	ctricia			Private		
	17. Fafhar's Name (First, Mide					18. Morher's Nam			Θ)	
To	Walter Bowm			19h Mailing	Address (Street	Marie .	Matthew		State Zin	Code)
treumetic event, the Mi	Angelia T.		ter			d Rd. Sui				0000)
other	20a. Method of Disposition		20b. P		tion (Name of story or other pla		Date	20c. Location -		wn, State
ry or	1 ☑ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe		State Ha	rmony M	lemorial	Park	8/4/00	Landove	er, M	d.
eny injury or other tr pncs.	21. Signatura of Funeral Serv	ica Licenario		22.	Nama and Addre	r S. Pope	Funera	1 Homes		20020
2 8	Kurtha	/hurce	M1085			nsylvania			ningt	
burial-transit au burial-transit au al Examiner	disease or condition resulting in deeth) Sequentially list conditions, if any leading to immediate	a	Due to (o	r as a consequ	enca of):	IDS OF H				
s the bur	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	d	Dua to (or	r as a conseque	enca of):		j _n s.			
od for	Part II. Other significant con-	ditions contributing to d	eath but not resu	ulting In the unc	derlying cause gi	ven in Part I.	23b. Dld	tobacco uss cor	ntributa to	the cause of death?
y Physician/M							10	Y88 20 No	3 Prol	bably 4 Unknown
should be							24a. Was	an sutopsy ormed?	av	ere eutopsy findings allable prior to mpletion of cause death?
tor, page 2							10	es 2 No	1	Yes 2□ No
Be Co	25. Was case referred to med examiner?	lical				26. Place of Deel	h (Check only	one)		
P P	1/∑ Yes 2 No		Inpatient 2		3LI DOA					at scene
pletely filled in by the funera edical Certification:	Z LI AUGIGUIII	estigation 7/12/	of Injury th, Day Year)	1550	M 1	ry at rk? Yes 2 1 No	SUB	how injury occurs SECT WY	45 St	
completely filled in by the f	4 Homicide del	ermined 28e. Place build		DED A	REA		City or To	Street and Numb wn, State) 44 ADITOL H	00 5M	ieu st
eletely fill		fying Physician: To the caf Examiner: On the b and man								
W Comp	29b. Signatura and title of con-	tilley 1	11		29c. Licens	se number		29d. Data signe	d (Month,	Dey, Year)
7)	11 -	W.1	no.	O.C	.M.E.		July 1	3, 2	000
	30. Nama and address door. MARY G.	RIPPLE, M		23a) (Type, P 111	rint) Penn S	treet, Ba	ltimore	, Maryla	and 2	1201
State	31. Date filed (Month, Dey, You AUG 0 3	32. F	legisfrar's Signa		books					

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State of Maryland / Department of Health and Mental Hygiene 00 26128

			Ce	ertificate of	Death		Reg. No.	0 20120
	1. Decedent's Neme (First, Midd	lle, Last)				2. Dete of D Month	eath Day	Yaer 3. Tima of Death
Physician /Medical	I THE TENENT IN	AE MORELAND				Augu	4	000 1016 1
Examiner	An English Manne Manne In adduction	on, give street and number)			4b. City, Town,	or Location of Dea		
	WASHINGTO	N COUNTY HOSP	ITAL		HAGERS			INGTON
Funeral Director	5. Social Security Number 236 - 40 - 8536	6. Sax 7. Age	(In yrs. last birthday	Months Days		Ain. 8. Date of Bi (Month, D		9. Birthplace (State or Foreign Country) NEST VIRGINIA
Pu	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or I	Location				10d. Inside City Limits
the Marylar 28a-f show notified at		RKELEY	MARTIN					1 ☐ Yes 2 ☐ No
vith the Mar t or 28s-f si pernormed	10e. Street and Number			10f. Zip Code			10g. Citizan of V	/hat Country?
death with the Maryland res 23a or 28a-f show trast be notified at ner al. Director	1124 5 WASI	HINGTON AVE.		254	401		USA	
Urs efter urs efter Ersents by Fur	3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	ver in U,S. 13	. Was Decedent of If Yes, specify Cu		? (Specify Yas or N uarto Rican, etc.)	o- 14. Race Blec Specify	e - American Indien, k, White, etc.
ind 21215-003 be filed within 72 hours lal Hygiene. d other than "natural", verit, fro Wide Ex	15. Decede	nt's Education est grade completed)	16a. Dec	edent's Usual Occure kind of work don	upation	working	16b. Kind of Bu	siness/Industry
within within then the	Elementary/Secondary (0-12)	College (1-4or 5+) life.	DO NOT use retir	ed)	Working		
filed within Hygiene. other than ent, the Me	8		A	SSEMBLY 1				NG GLASS
Aaryland 2 2 should be filed and Mental Hygis is marked other sumatic event,	17. Fathar's Nama (First, Middla GEORGE HOME				1 1 1 2 2	Name (First, Middle		θ)
Marylan 12 should be h and Mental r is marked or traumatic eve						EL MAE DU		0.1. 7. 0.1.
Manda and The	19e. fnformant's Neme/Reletion PAUL W. MOREI					Rural Routa Numi		State, Zip Code)
CHAL	20a. Method of Disposition	LAND / SUN	20b. Place of Dis	position (Name of	-	Date Date		City or Town, State
Pages nent of int: If it	1 🖾 Burial 2 Cremetion 4 Donation 5 Other (5	Specify)	CENTRA	ematory or other pl L CHAPEL	E.,	8/7/00	R.F.D. H	IEDGESVILLE, WV
Baiti Permit. Departm Importa any inju	21. Signature of Funeral Sarvice	M. Brown				ME, 327 V INSBURG,		
100	23a. Pert1. Enter the disease, of	r complications that caused to t only one cause on each line	he death. Do not e					Approximate Interval Between
requires that the death certificate be assecuted requires that the death certificate be assecuted hould be detected for use as the bunet-transit neted by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Out	ue to (or es e consule to (or es a consule to	enter equence of):	heat	direin		
A cio		d	layon	n les	Calu	lu		
IS, P.O. BOX es that the death ce igned by the attendi be detached for use by Physiclan/	Part II. Other significant conditi	ions contributing to death but	not resulting in the	undarlying causa ç	given in Part f.		tobacco use co	ntribute to the cause of death?
							s an autopsy formed?	24b. Were autopsy findings svailable prior to completion of ceuse of death?
The lew ate has page 2						10	Yes 2 No	1 Nes 2□ No
felan: The certificate rector, pag	25. Was casa raterred to medical	al /			26. Place of	Deeth (Check only	one)	
	axeminer?	Hospital:	t 2 ER/Outpati	ent 3 DOA	ther: 4 Nursin	ng Home 5 □ Res	sidence 6 Oth	er (Specify)
After fune	27. Manne of Death 1 Protection 5 Pending Pending 2 Accident Nest 3 Suicide 6 Could 4 Homloide	igation	y - At home, ferm, s	M 1[☐ Yes 2☐ No	28f. Location	Street and Numb	red ver or Rural Routa Number,
To the Hospital or Attention within 24 hours after deet To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the best of t Examiner: On the basis of e	xamination end/or	eth occurred at the Investigation, in my	time, date and p	lace, and due to the	e ceuse(s) and me	enner as stated. and due to the cause(s)
To the I within 2 To the complet	29b. Signature end title of contrib	and manner state	BG.	29c Lica	nse number		29d. Date signe	d (Month, Day, Year)
F 1 5 8	255. Signature end that di dalla	11	^	250. 21081			C /	14/2
	1/4/	Ly M					8/	7/00
	30. Neme and address of person	: Wack	H, m.L	e, Print) D_ 11/1	o medic	ca L Can	your Ar.	14 mo.
State Registrar	31. Dete filed (Month, Day, Year AUG 0 7		's Signature	Spor	W		/	0 21742



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State of Maryland	/ Department of Health	and Mental H	lygiene UU	2012

		Certificate of Death	Reg. N		
	Physician /Medical	1. Decedent's Namo (First, Middle, Last) S. Mc Coy	2. Dete of Death Month D	Dey Year	3. Time of Death
	Examiner	Gernet (Gunty Many or all Hospital Oakle	cation of Death	ic. County of Death	T
	Funeral Director	5. Social Security Number 235-42-7250 6. Sex 1 Months Days Hours Min.	8. Date of Birth Month, Day, Yes 01-23-19		lace (State or Foreign try) Virginia
	t show sd.st.	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location WV Kanawha Handley		1	0d. Inside City Limits
	23e or 28e-f sh at be notified a	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Coun	try?
020	ur, or items 23 Examiner must by Funeral	If Yes, Give 1 Yes 2 14 No Specify: Year or Detes:	cify Yes or No- Rican, etc.)	14. Rece - Americ Black, White, Specify:Whit	etc.
21215-0020	ygiene. Net than "naturn", the Medical.	15. Decedent's Education (Specify only highest grade completed) Elemantapy/Secondary (0-12) Collega (1-4or 5+)	ng	Kind of Businass/Inc	
		17. Fether's Neme (First, Middle, Last) Owner/operator 18. Mother's Name	(First, Middle, Meide	staurant	
Maryland	Mental H inked oth affic sver	7 0 11	gdaline		
ary	T T	19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rura	~		
	er tra	Mary Falbo/ daughter 639 Fayette Pike Mo			
altimore	nant of He ant: If then ury or oth	20a. Method of Disposition 1 A Buriat 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of Kanadyn ar after place) Kanadyn Valley Memorial Gardens 8		Location - City or To	
Balt	Depart Importa	21. Signature of Furneral Service Licenses Hinkle Funeral Hope P.O. Box 186 Day:	ome		
7	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or shock, or heart failure. List only one causa on each line. Immediate Causa (Final disease or condition rasulting in death) Due to (or as a consequence of):		CUA	Approximate triterval Between Onset and Death
×	een cernicate be executed ethoding physician and for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of):			
0	by the sached	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobac	^	the cause of death?
ords,	been signed should be d		24a. Was an au performed?	? av	ere sutopsy findings allable prior to mpletion of ceuse daath?
	ate hes page 2		1 ☐ Yes	7	☐Yes 2☐ No
ital	yacters: me les se certificate has director, page 2 To Be Comp	25. Was case referred to medicat 26. Placa of Death	(Chack only one)		
of Vital	00	1 Yes 20 No Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 Residence		y)
	After funer	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how in	njury occurred	
	an or Americang resident death. In Director: After the did in by the funeral Certification:	2 Could as the	28f. Location (Street City or Town, Ste	end Number or Rura ete)	Il Route Number,
	which a company of the complete of the complet	29a. Cartifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and the control of the best of my knowledge, death occurred at the time, date and place, and the control of the best of my knowledge, death occurred at the time, date and place, and the control of the best of my knowledge, death occurred at the time, date and place, and the control of the best of my knowledge, death occurred at the time, date and place, and the control of the best of my knowledge, death occurred at the time, date and place, and the control of the best of the best of my knowledge, death occurred at the time, date and place, and the control of the best of			
	To the comp	29b. Signeture and title of certifier Paul Dayur Muller H 26 154	29d. I	Date signed (Month, 8/9/0)	Day, Year)
	5	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 69 Walk Occep Drue Ouhlang	el me	1215	50
	State Registrar	AUG 1 7 2000 Server & Signature & Society			

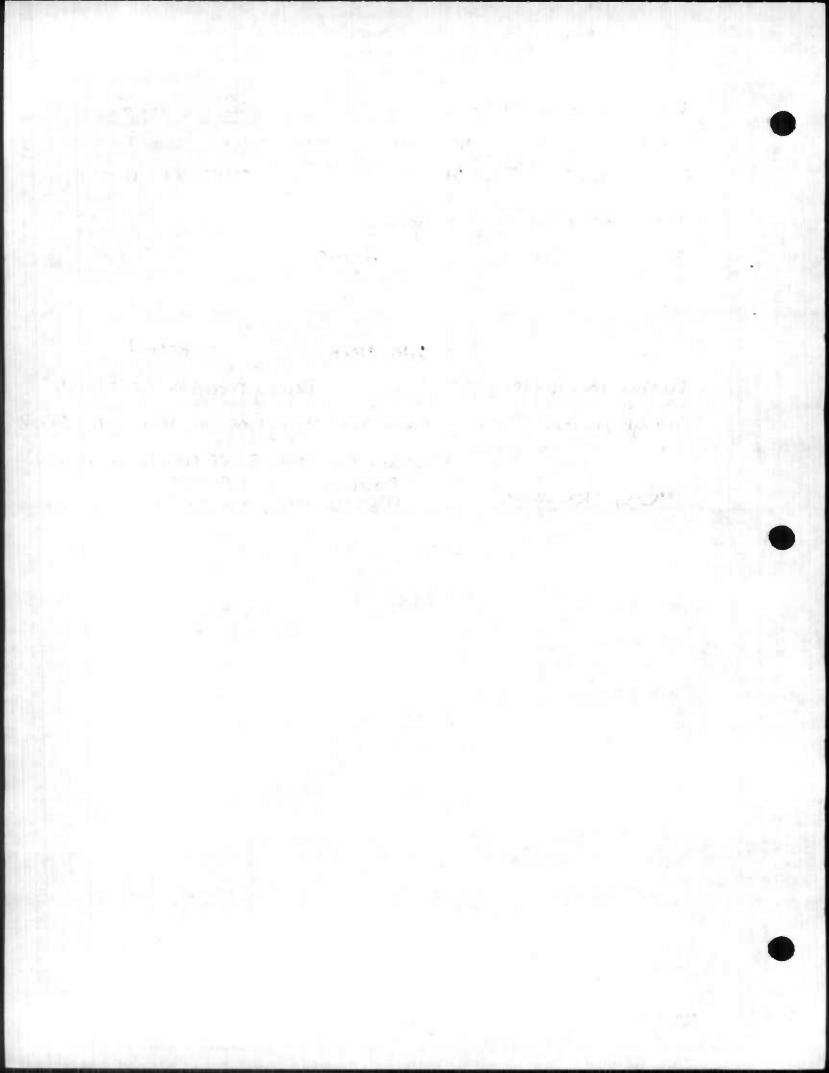
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State of Maryland / Department of Health and Mental Hygiene 10 25130.

		Certi	ficate of	Death	Reg	J. No.	20100
1. Decedent's Neme (First, Mid	dia, Last)				2. Date of Death Month	Day Yea	3. Tima of Death
edical Louise mo	arie Mye	v 5			august	4. 200	and the same
niner 4a Facility Neme (If not institute	lon, give street end number)	Bear Street	Sund	4b. City, Town, or	Location of Death	4c. County of De	eth
Washington				Hagerst		WASh	ington
5. Sociel Security Number	6. Sex	N yrs. rest bittroay	f Under 1 Yeer lonths Deys	If Under 24 Hrs Hours Min	. (Month, Dey, Y	(ear) 9. B	irthplace (State or Foreign
232 32 5466		TI Yrs.			0405	M PE	ichigan
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10e. Street and Number	ringion	Hagerst	10f, Zip Code		100	2. Citizen of What (Country?
		9		•	101	U.S. F	
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11. Meritel Stetus 1 Never Merried 2 Me	12. Wes Decedent Ev Armed Forces?	of in 0,5.	es, specify Cub	en, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, Wh	
3 Witdowed 4 □ Divorce	If Yes, Give	10	Yes 2 No	Specify:		Specify: -	10
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	nest grade completed)	(Give kin	d of work done NOT use retire	during most of wo			
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Cuther Poi	ndexter			Densei	mani	la Rod	abush
19a. Informant's Name/Raletion		19b. Mailing /	Address (Street		urel Route Number, (
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20a. Method of Disposition)	20b. Plece of Dispositi cametery, cremat	on (Name of			c. Location - City	
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Immediate Cause (Finel	011		1.				2
disease or condition resulting in deeth)	· KILA	TOVAL	Pre	Undo	14		Lusers
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	b						1
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury	D	ue to (or es e consequa	nca ot):				
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Cause (Disaase or Injury that initieted evants resulting In death) Lest	Di	ue to (or es e consequer	100 01):				1
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Part II. Other eignificant condi	tions contributing to death but	rior resulting in the µnde	rrying causa gi	ven in Per I.			Deshably 4 1 Helen
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	1-0-17				24a. Wes en	eutopsy 24t	b. Wera autopsy findings available prior to
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						_	of death?
					1 🗆 Yas	2 110	1 Yas 2 No
25. Wes casa rafarred to medic examiner?	Hospital:		Ot	har:	ath (Chack only ona)		
1 Yes 2 No	1 Les inpatient		3LI DOA	4 LI Nursing	Home 5 Residen		pecify)
1 DNatural 5 Pend		(ear) 28b. Tima of Injury	28c. Inju Wo	rk? Yes 2□No	280. Describe now	injury occurred	
27. Manner of Death 1	d not be	A45		Tes ZUNO	206 Location (Ctm	at and Alimbar as	Rurel Route Number,
4 Homicida deter	building, atc.	- At homa, farm, street (Specify)	, ractory, office		City or Town,	Stata)	Hurer House Number,
(Check only 2 Medical	ing Physician: To the best of a Examiner: On the basis of e	xaminetion end/or inves	curred et the ti ligation, in my	ma, data and plac opinion, deeth occ	e, and dua to tha cau urred et the time, dat	isa(s) and mannar a and place, end d	as stated. lua to the cause(s)
	and manner stete	d.	000 110	an aumbre		I Date sized (44)	auth Day Varia
29b. Signeture end title of certif		\cap	29c. Licans	T C	23 139	d. Date signed (Mo	onin, Day, Tear)
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30. Neme and address of perso	n who complated causa of das	th (Item 23a) (Type, Pri	nt)	1 (2)	US 12017.	D HA	(FLITTERN)
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31. Date filed (Month, Dey, Yea	r) 32. Registrar	s Signeture					. 17
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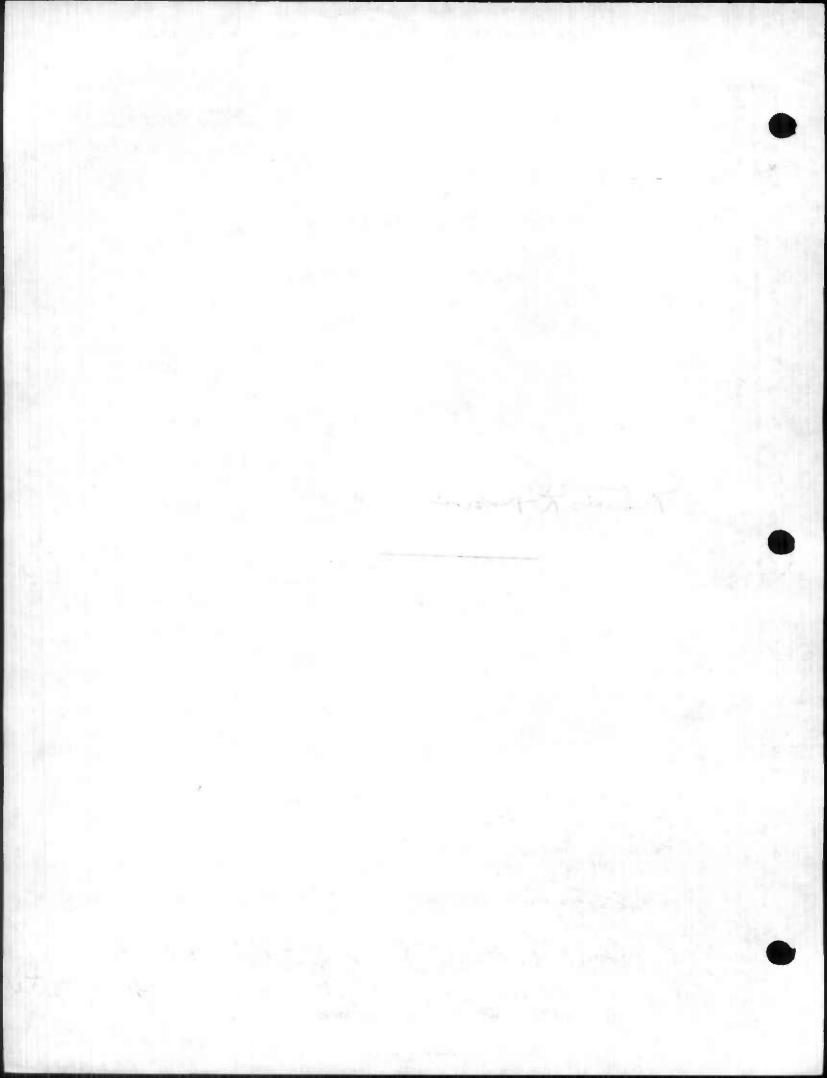
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23a perPHYG786 8/17/2000 EW 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Month **Physician** Charles Earl Murray 16:35 JUNE 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Yaar | If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Hours 10 M 20 F 79 Yrs. Aug. 16, 1920 Dirěctor 245-12-8691 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Hagerstown Director Md. Washington 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? U.S.A 21742 1014 Woodland Way Berns 23a Funeral 12. Was Decedenf Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Ø Yes 2 □ No If Yes, Give 42-45 Yaar or Datas: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 🛱 No Specify: specity: White à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Emma Whitman should be Orion Murray 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
1014 Woodland Way Hagerstown, Md. 21742 19a. Informent's Neme/Relationship (Type, Print) ã (Wife) Lelia R. Murray riment of Health riant: If Item 27 20b. Plece of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Pages thent of h 1 Burlal 2 Cremation 3 Removal from Su 4 Donetlon 5 Other (Specify) ò Smithsburg Crematory June 13, 2000 Smithsburg, Md. 5 Other (Specify) Signature of Funeral Service Lim 22. Nama and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deat Physician ACUTE METABOLIC /Medical Immediate Cause (Final disaase or condition resulting In death) Examiner Examiner attending physician and for use as the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that included ease of the cause (Disease or Injury) 68760 Physician/Medical that initiated events resulting In death) Last Due to (or as a consequence of) Box P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 After this certificate has 2 No 1 ☐ Yas 2 ☐ No 1 Yes 25. Was case reterment medical Be 26. Place of Death (Check only one) 1 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 27. Manner of Death 28c. Injury of Work? Certification: 28d. Describe how Injury occurred Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (County) 4. C. Homicide To the Hospital Wiltin 24 hours a To the Funeral C Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

Lead al Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29s. Certifier State

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

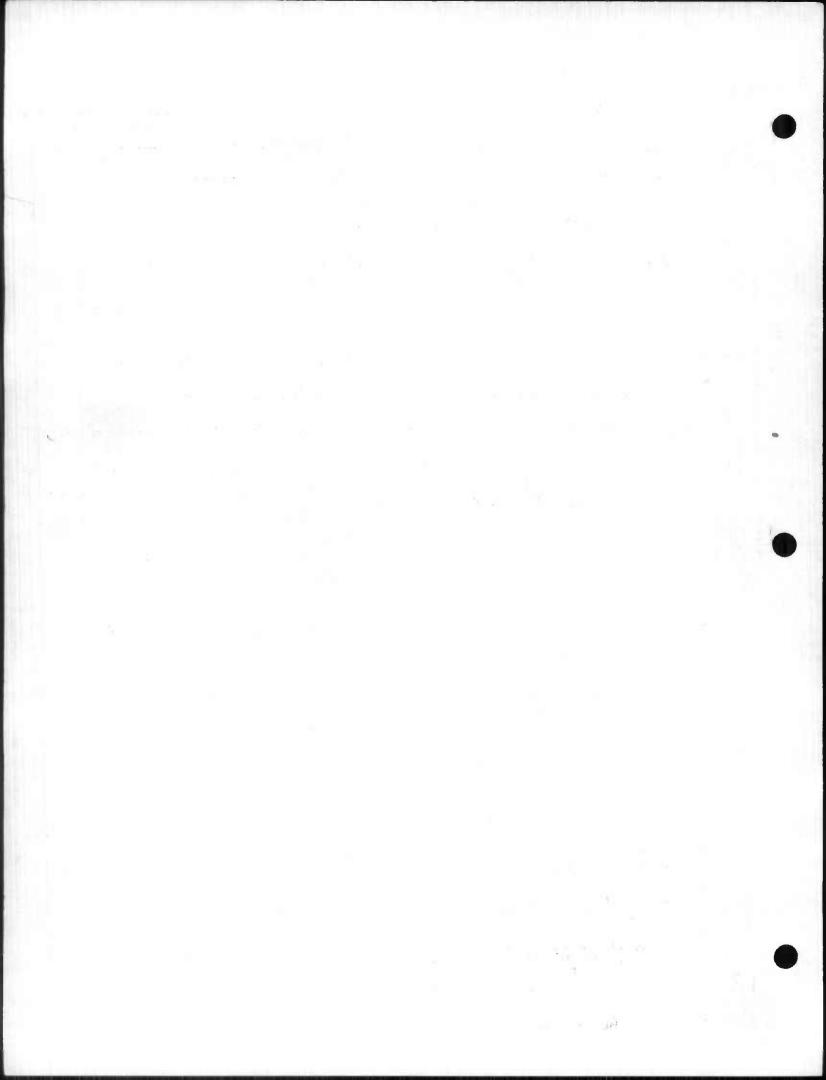
Certificate of Death 2. Date of Death 3. Time of Death Month Year **Physician** 4a Facility Nama V not institution, give street and number) 2000 0 1:10 am /Medical 4c. County of Deeth 4b. City, Town, or Location of Death **Examiner** 101 Spotclub Road Anne Arundel Arnold Il Undar 24 Hrs. If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days 10 M 2□ F 52 Yrs. Director Jul 26,1948 New York 118-40-1729 Usual Rasidanca of Decedant 10c. City, Town or Location 10d. Inside City Limits 10a. Stata or Herne 23a or 28a-f show 1 ☐ Yes 2 XNo Director Anne Arundel Arnold the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 101 Spotclub Road 21012 USA Funeral 12. Was Dacedent Evar in U,S. Armed Forcas? 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Stefus 1 ☐ Yas 2 █No If Yas, Giva 1 Nevar Marriad 2 Married 1 Yes 2 No White Maryland 21215-0020 à 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Lodging Company Risk Manager 18. Mothar's Nema (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Pages 1 and 2 should be Robert Bryant Marsh Catherine Zuromsky 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) . nt of Health : : If Hem 27 is Maureen H. Marsh/Wife 101 Spotclub Road, Arnold, MD 21012 Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 DBuriel 2 ☐ Cremetion 3 ☐ Removel from State Aug 4 Davidsonville, MD 4 ☐ Donetion—5 ☐ Other (Specify) Lakemont Memorial 2000 21. Signature of Furniral Service Ligenson 22. Nama and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Cov. Ritchie Hwy, Severna Park, MD 21146
Approximate
Approximate Part Enter the disease, or complications that caused the deeth. Do not enter the style, or heart failure. List only one cause on each line. Physician Immediata Ceuse (Final disaesa or condition resulting in death) /Medical 10 month Examiner Due to (or as a consequence of): Physician/Medicai Examin that the death certificate be executed Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Couse (Disease or injury that Initiated evants resulting in death) Last Due to (or as a consequence of): es the burial-trer Box 68760. Due to (or es e consequença of): P.O. 1 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 25 No 3 □ Probebly 4 □ Unknown 3 λq Division of Vital Records. should be The law requires 24b. Wara autopsy findings available prior to comptation of causa of death? 24a. Was an autopsy Be Completed Deed this certificate has 1 Yas No 1 ☐ Yas 2 ☐ No Physician: Director: After this certific in by the funeral director, 25. Was casa rafarred to madical 26. Plece of Deeth (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home Residence 6 Other (Specify) Medical Certification: To 27. Manpar of Death Natural 2 Accident 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury at Work? if or Attending P 5 Panding Invastigation 1 Yas 2 No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida 28a. Placa of Injury - At homa, farm, streat, fectory, offica building, alc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29b. Signeture end titla of certifie 30. Neme and addrass of person who completed causa of death (tem 23a) (Type, Print) Gracus st, Baltimers MD 1 vav KLYOND 31. Data filed (Month, Day, Year) 32. Registrer's Signature State Registrar

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1009		1. Decedent's Nar	ne (First, Middle, L	ast)			ificate	011	J Guill	2. Date of D	Reg. I	NO.		3. Tima of	Death
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/Medic Examir				ive street and number,		110111	.00	4	lb. City, Town, or			¢c. County		7:30	A.M
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Funeral		5. Sociel Security	OFFISVI Number 6.	lle Road Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1	Yeer	If Under 24 Hrs	6. Date of B				ace (Stete o	r Foreian
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yland		10a. State	10b. County		10c. City,	Town or Loca	ation						10	d. Inside Cit	y Limite
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ter dea	Funeral	11. Merifel Status		12. Was Decedent Armed Forces	Ever In U,S	5. 13. W	as Deceden	of H	ispanic Orlgin? (S in, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Raci	e - America	n Indian,	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month **Physician** Alex Eugene NAVE 8:57 P.M. August 2,2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 14898 Bottom Road Williamsport If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 □ F Yrs. 220-09-9256 89 Director April 22,1911 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 ☑ No Director 288-1 Maryland | Washington Williamsport 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? Nerna 23a or 21795 USA 14898 Bottom Road Funera permit. Pages 1 and 2 should be liled within 72 hours after deal Department of Health and Mental Hygiens. Important: If New 27 is married other to. 900s. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: à 3 ₩ Widowed 4 Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Brick Manufacturer Laborer 6 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 10 Ella Mae Teach Alex Bradley Nave 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1054 Arnoldstown Rd. Jefferson, MD 21755 M.Regina Mentzer/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) Pinesburg Mennonite Cem.8-5-00 Williamsport, Maryland 21. Signature of Funeral Service Lices 22. Name and Address of Facility Osborne Funeral Home 425 S.Conococheague St. Williamsport,MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 98 for use Division of Vital Records, P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown ٥ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2 No certificata or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Magner of Death 28b. Time of 28c. Injury et Work? 5 Pending investigation Naturat 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital edical 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and add ess of person who completed cause of death (Item 23ap (Type, Print) 281 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State AUG 0 4 2000 Registrar

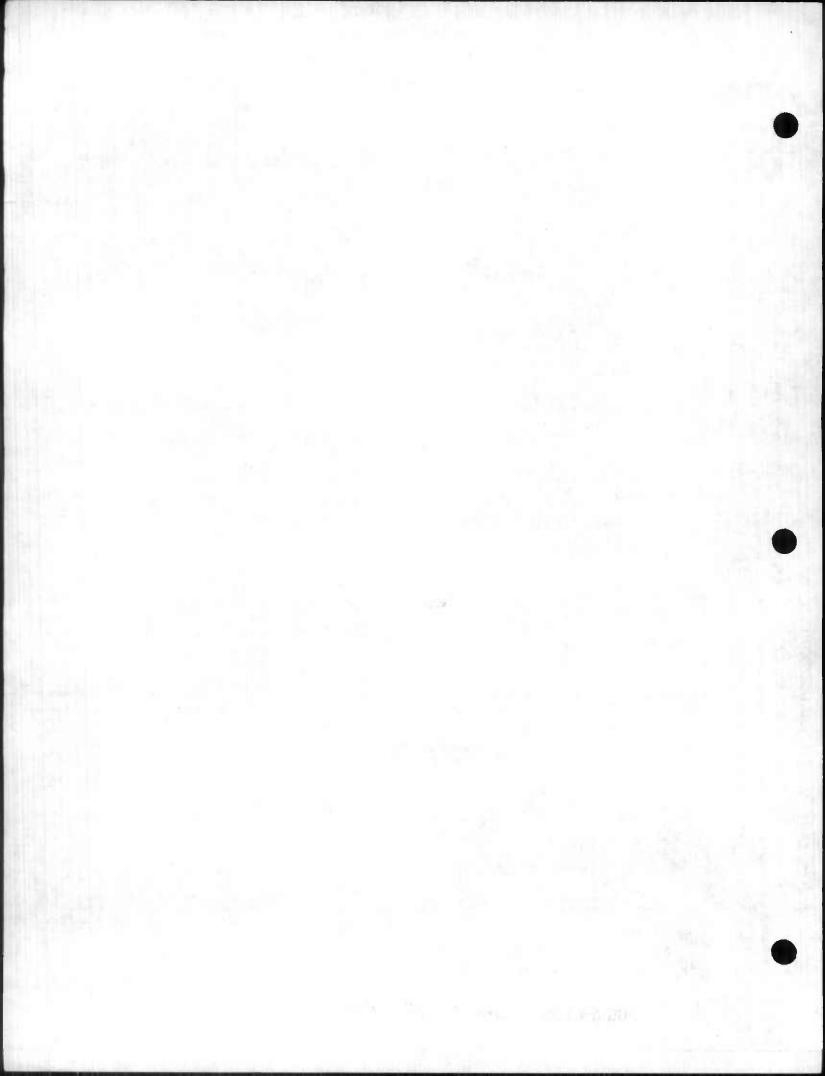
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State of Maryland / Department of Health and Mental Hygiene

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NOLL, ELIZABETH WILHELMENA



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State of Maryland / Department of Health and Mental Hygiene 00 26137

			Certific	ate of Death	Re	g. No.	20101
	1. Decedent's Nama (First, Middla, Las	it)			2. Date of Death	1	3. Tima of Death
Physician /Medical	Doris McGinnis	Neall			Month August	Day Year 1 2000	6:50 AM
Examiner	4a Facility Nama (If not institution, give			4b. City, Town, o	r Location of Death	4c. County of Deal	th
	829 W. Central Av	7e.		Davidson	ville	Anne Ar	undel
Funeral	5. Social Security Number 6. Se	ex 7. Age (In yrs		der 1 Year If Under 24 Hr	s. 8. Date of Birth		thplace (Stata or Foreign ountry)
Director	213-09-4565 Usual Rasidence of Decedant	□M 2\\ F 85	Yrs. Mont	hs Days Hours Min	May 20,	L915 Ma	ryland
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or 28s-f s be notified Directo	MD Anne Arur	rger D	avidsonvil.	L E Zip Code	10	a. Citizen of What Co	untar?
23e or unt be u		Ave.	10.	21035	10	USA	ontry :
her death virthere 23 siner ment	11. Marital Status	12. Was Decedent Ever in	U,S. 13. Was De	cedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame	
Maryland 21215-0020 nd 2 should be illed within 72 hours after hit and Mental Hygiene. T is marked other than "natural", or its traumatic event, the Medical Examins To Be Completed by Fu		Armed Forces? 1 ☐ Yas 2 1 No If Yes, Give Year or Datas:		s 2X No Specify:	nto Hican, etc.)	Black, White	a, atc. hite
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Abental Abental Reserved Bic ev	William Hill McGi	innis		Tabith	a Tucker		
THE PERSON IN	19a. Informant's Name/Ralationship (T		19b. Mailing Addr	ess (Street and Number or F		City or Town, Stata,	Zio Code)
and 2.	Susan N. Murnane /			een Meadow La			
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Mattimore, semil. Pages 1 ar separtment of Health portant; if Item 2 mportant; if Item 2 my Injury or other 2008.	XXBurial 2 Cramation 3 DI	Removal from Stata	cemetery, crematory of	or other place)			
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To the Hospital within 24 hours of the Funeral Completely filled	29a. Certifier 1 Certifying Phy cone) 1 Medical Exami	sician: To the best of my kn iner; On the basis of axamin and mannar stated.	nowledge, death occurrenation and/or investigate	ed at the time, date and plac- ion, in my opinion, death occ	ce, and due to the cau curred et the time, da	use(s) and mannar as te end place, and due	stated. to the cause(s)
Me of the	29b. Signatura and vitla of certifier	0		29c. License number	29	d. Date signed (Mont	h, Day, Year)
F 3 F 8	J. Jell	mulisus		019838	3	8/1/200	00
	30. Nama and addrass of person who con STUAUT E. S	ompleted cause of death (Ne		Bastgate R	Rd. Auv	rapolis,	Ma. 21401
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	loo de			

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State of Maryland / Department o

of Health and Mental H	ygiene	nn	2	6	1	3
of Death	Reg No	00	Sec.	0	ě	U

VW						Certifica	te of	Death		Reg. No.) (.0130			
1 - 1		1. Decedent's Name	(First, Middle, La	ast)		31, 23,			2. Date of Der Month		Year	3. Time of Death			
Physicia /Medica		Timorny II Nelmiller								3, 2000	roai	8:20 P.M			
Examine		4a Facility Name (#	not institution, giv	ve street and number)			4b. City, Town, or L	ocation of Death	4c. County	4c. County of Death				
K-SL		WOODLA	ND BEACH					EDGEWATE	R	ANNE	E ARU	NDEL			
Funeral Director		5. Sociel Security No. 214-88-49		Sex 7. A 1□XM 2□ F	ge (In yrs. last bi	Yrs. If Under	or 1 Year Deys		8. Date of Birth (Month, Day Aug 22	, 1961	9. Birthp Coun Mar	leca (State or Foreign try) y Land			
9	Director	Usual Residence of			140 00 7										
Marylei H show			MD MD	10b. County Anne Ar	undel	10c. City, Tov	ern					"	0d. Inside City Limits 1 ☐ Yas 2 🖔 No		
28		10e. Street and Num	ber		1	10f. Z	ip Code			10g. Citizen of W	Vhat Coun	try?			
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72 hours effer death with the Maryland natural, or flores 23a or 28a-f show deat Exampler must be motified as	Funeral	11. Marital Status 1 Never Marrie	ed 2 Married	12. Wes Decedent Armed Forces 1 Yes 2X If Yes, Give	?	13. Was Dec		Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Blec	k, White,				
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pemit. Pag Department Important: I eny injury o		21. Signature of Fur	neral Service Libe	0_0	0			ess of Facility John f Glouces				Home, Inc.			
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the death cerry the attendin		Part II Other elanifi	cant conditions	d	but not resulting	in the underlying	Cause O	iven in Part I	23h Did i	lobacco usa cor	ntributa te	the cause of death?			
EXT		Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						ld tobacco use contributa to the cause of de							
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The law ate has page 2	E								1,50	res 2 No	1,5	Yes 2 No			
certificate rector, par	0	25. Was case referr	ed to medicaf					26. Place of Dea	th (Check only o	one)					
Physician: this certific ral director,	0	examiner? 1⊠ Yes 2□1	No	Hospitel:	ient 2 ER/O	utpatient 3 0	DOA O	thor:		dence 6 (XOth	er (Specif	w scene			
or Attending Physelector: After this bir by the funeral din by the funeral din	⊢	⊢				27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 28 No Subject drowned 28b. Time of Injury M 1 Yes 28 No Subject drowned 28b. Time of Injury M 1 Yes 28 No Subject drowned 28c. Injury et Work? 1 Yes 28 No Subject drowned 28c. Injury et Work? 1 Yes 28 No Subject drowned 28c. Injury et Work? 28c. Injur									
Hospi 24 hou Funer stely fill	edical Cer	29a. Certifier	1 Certifying Pt	nyaician: To the basis and manner s	P1CC a of my knowledg of examination a	e, deeth occurre	d at the t	ime, date and place,	Anne Ar	couse(s) and ma	oun +	Manyland			
To the Within To the comple	Ž -	29b. Signature and	title of certifier	and mainer s		2	9c. Licen	se number		29d. Date signed	d (Month.	Dey, Year)			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day 2000 **Physician** Month Phillips George 29, July 10:35 AM /Medical 4a. Facility Neme (If not institution, give street end number) 4b City Town or Location of Death 4c. County of Death **Examiner** Gaithersburg Wilson Health Care Center Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth | Months | Deva | Hours | Min. | 8. Deta of Birth | Months | Deva | Hours | Min. | Month, Dey, Year | 9 12 | 9. Birthplaca (Steta or Foreign Country) 6. Sex 1∆ M 2 ☐ F 7. Age (In yrs. last birthdey) **Funeral** 577-16-6995 Yrs. Director December 14, South Carolina Usual Residence of Decedent pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Hedical Exercise must be notified and 2008. 10b. County 10c. City, Town or Location 10d. Inside City Limits District of Columbia Washington Was 2 No Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 4500 Dix Street, N. E. 20019 United States Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wea Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indian Black, White, atc. 1 Never Married 2 Married Black. 1 Yes 24 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th grade Construction Construction Worker 17. Fathar's Nama (First, Middle, Last) 18. Mother'a Nema (First, Middla, Maidan Surnama) Be Mack Phillips Julia (unknown) 2 19a. Informant's Neme/Ralationship (Type, Print) Ervin Phillips, Sr. (son) Viola Smith Phillips (wife) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4500 Dix Street, N.E.; Washington, D. C. 20019 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery/Aug.3,2000 Brentwood, Maryland 22. Neme and Addrass of Facility
R. N. Horton Company Morticians, Inc. 21. Signature of Funaral Sarvice Licansee 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory arrest, shock, or heart feilura. Liat only ona causa on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final Grancopheumenia disaasa or condition resulting in daath) Examiner Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician end the buriel-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Couse (Disaase or Injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequenca of): 80 US8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. signed by the e 23b. Did tobacco ues contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 PrUnknown þ Completed 24b. Were autopsy findinga aveilable prior to completion of cause of death? 24a. Wes an eutopay performed? Theroscleratic Heart Disease certificate has t irector, page 2 s 1 Yes 2 No 1 ☐ Yea 2 ☐ No or Attending Physician: 25. Was case refarred to medical exeminer? Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel 5 Pending Invastigation 1 TYes 2 No 2 Accidant s after death 3 Sulcide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, etreet, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral C Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as ataled. edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Wisconsin Are Cheny Chose Am Musher 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State AUG 0 4 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene Amend #20b.& 20c.Per Family PGC 8-11-2000 cr Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month July **Physician** 28^{bay} 2000 Willie C. Pridgen 10:12PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 24 Hrs. 8. Dele of Birth (Month, Day 3 Year) 1955 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Months Days Hours 1☑M 2□F 578-78-5778 44 Wash. D.C. Director **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland | Prince George's Director Landover 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 3419 Dodge Park Road 20785 United States Berrie 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1☐Never Merried 2☐ Merried **Black** 1 Yes 2 No Specify: 8 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A permit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important; if Item 27 is marked other any Injury or other traumatic event, 21 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Willie C. Pridgen Sr. Frances M. Pollard 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20745 Betty J. Dantzler - Sister 525 Wilson Bridge Dr., #C-1; Oxon Hill, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Forest Hill Memorial Gardens 8/4/2000 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensei Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque attending physician for use as the buria Box 68760. endo con Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.O. 23b. Did tobacco use contribute to the cause of death? menficeenery 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed Regunsitation 1 Yes 20 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? or Attanding Physician: Be 26. Place of Death (Check only one) Hospital: 1 ponpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After 1 Naturat 5 Pending investigation n 24 hours after death. The Funeral Director: After the funeral forms of the funeral forms of the funeral funeral forms of the funeral 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title-of certifie 29c. License number 29d. Date signed (Month, Dey, Year) D 24720 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6/32 Landoven Road, R. RUSTAGI 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 0 2 2000 Registrar

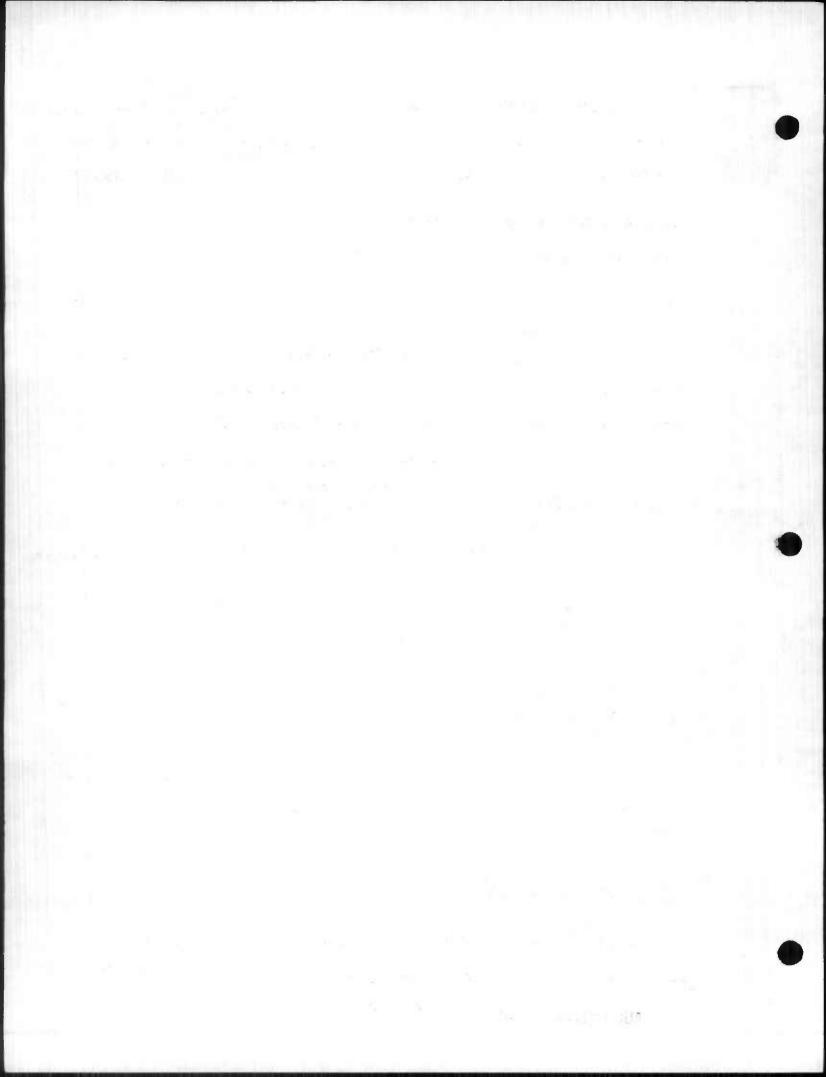
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		t Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of the Contro	(y)		Lincoln Ceme		3/4/00	Brentwo	od. N	(D)	
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 19, Mary Ella Payne 2000 4:30PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Care Bethesda Montgomery If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1□ M 2□ F 95 Yrs. 229-28-3686 VIRGINIA Director Jan. 3, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No Director MARYLAND MONTGOMERY BETHESDA 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? herne 23a or r than "natural", or hame 23s or the Medical Examiner must be. 5721 GROSVNER LANE 20814 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK by 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 6th 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be ind Mental is marked AURTHUR MAIDEN SARAH HALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If Hem 27 is 1 2104 Banning Place Hyattsville, MD 20783 PATRICIA ANN JONES/ GRANDDAUGHTER 20b. Placa of Disposition (Neme of cametery, crematory or other place) CEM. 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 K Removal from State 7-24-00 MONTROSS, VA 4 ☐ Donation 5 ☐ Other (Specify) GALILEE BAPTIST CHURCH 21. Signature of Funeral Service Licent 22. Name and Address of Fecility MARSHALL'S FUNERAL HOME OF MD mbelle 4308 SUITLAND RD. SUITLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cerebrovascular Disease weeks Examiner Due to (or as a consequenca of): Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. attending physician Physician/Medical as the Due to (or es a consequence of): P.O. | signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Deep Venous Thrombosis Records, by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to page 2 should Completed completion of cause of death? has 1 ☐ Yes 2 No 1 Yes 2 No repital or Attending Physician: The hours after death.
Ineral Director: After this certificate filled in by the funeral director, pa Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 10 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) 29b. Signatury and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D20516 July 26, 2000

State

Registrar

Date filed (Month, Day, Year)

Schulman,

Toe1

32. Registrar's Signature AUG 0 1 2000

address of person who completed cause of death (Item 23a) (Type, Print)

M.D

back

9410 OLD GEORGETOWN RD. BETHESDA, MD

20814

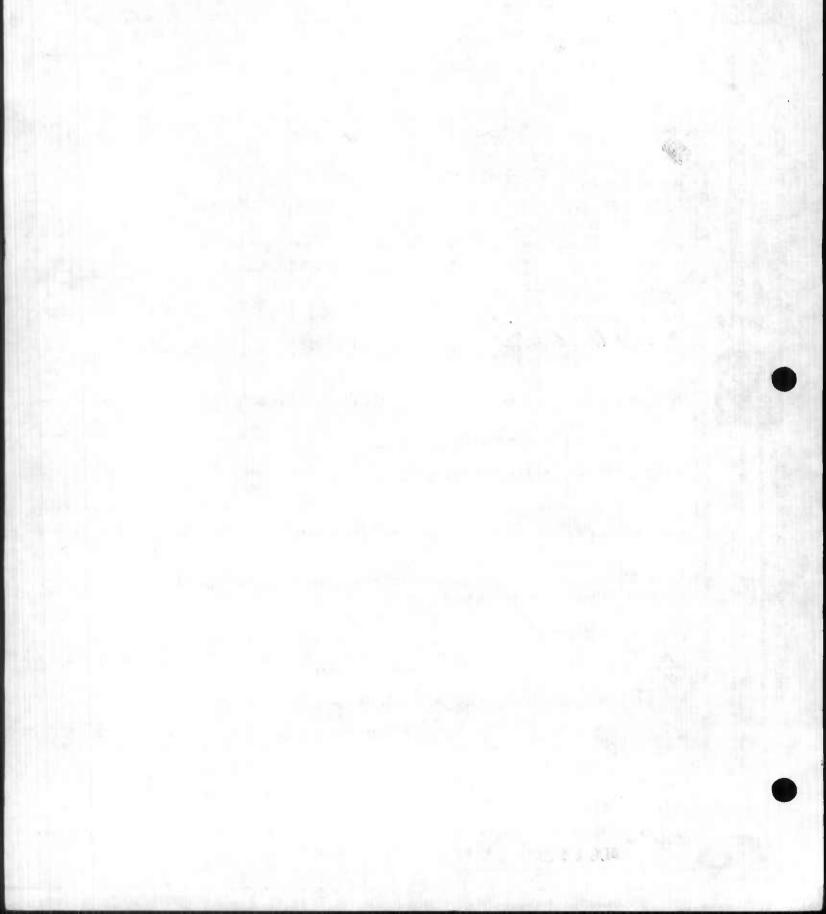
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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P.O.	ed by the attendir detached for use Physician/R	To the organization of the contributing to death but not resulting in the underlying cause given in Part i.						1 Yes 2 No 3 Probably 4 Unknow						
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Division of Vital Records, or Attending Physician: The law requires to effer death.	cate has been signed by the attendi , page 2 should be detached for use Completed by Physician/									24a. Was	an autopsy	24b. W	ere autop	sy findinga ior to
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Division of Vital Re To the Hospital or Attending Physician: The M	T O	20a Cartilias	40 0 44 1-			are distance in			Annual Calabara and a second					
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	State Registrar	-communication	AUG 0	6 2000	Dener	1	7. A	4000	102					



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Physician /Medical Examiner Rebles **Funeral** Director 10e State Md. Director Elizabeth Funeral 11. Meritel Stetus 21215-0020 by Completed Margaret Baltimore, Maryland 96 1 and 2 should be Health and Mental If ham 27 Pages 1

Physician

/Medical

94

US0 88

After this certificate

funeral director,

completely filled in by

or Attending Physician:

death.

To the Hospital or Attend within 24 hours after death To the Funeral Director:

Examiner

The law requires that the death certificate be asscuted

Box 68760

Division of Vital Records, P.O.

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Margaret Elizabeth Peebles 4, 2000 5:20 PM August 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Boonsboro Washington If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country)
Texas 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 10, 1922 Days Hours Months Yrs. 458-14-3534 77 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 268 S. Potomac St. 21740 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) Coltege (1-4or 5+) Aeronautics Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Hickman Anna Margarete Krebs 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 426 Manilla St. Greenville, Miss. 38701 (Daughter) Vicki S. Durso 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Reproval from Smithsburg Crematory Smithsburg, Md. 5 Other (Specify) Signature of Juneral Service Lice 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death Immediate Cause (Finat disease or condition rasulting in death) slow 6 moult Cance Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, teading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? 2EI No 1 Yes 2 No 25. Was case rafarred to medicat examiner? 26. Place of Death (Check only ona) Hospital: 1 Inpatient Other: Mursing Homa 5 Rasidence 6 Other (Specify) 1□ Yes 2□ No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Naturat 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida JEC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32518 Mb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/ 301-432-2222

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

26/44

DHMH 16 Rav 6/95

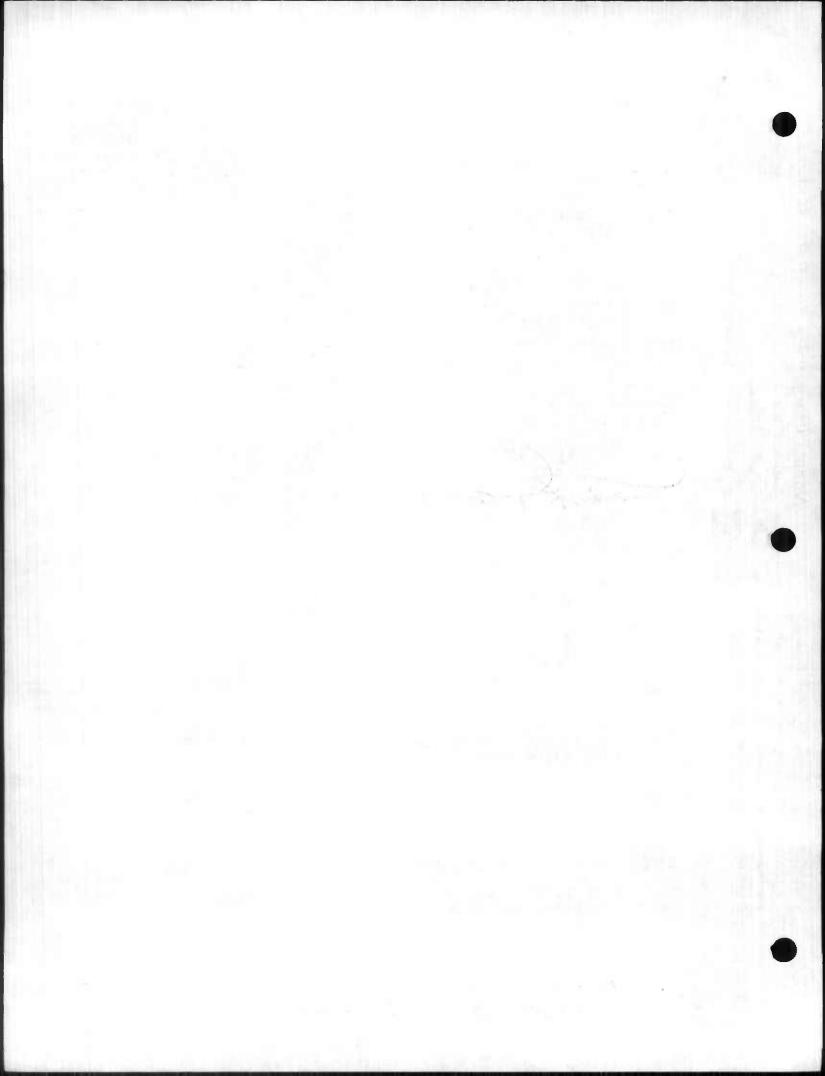
State

Registrar

32. Registrar's Signature

AUG 07

2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 07 Physician Audrey May
4e Facility Name (If not institution, give street and number) 27 2000 5:22 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington a ten Hospital
Age (In yrs. last birthday) If Un Fort Woshing fon, no r tf Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 XF 70 Yrs. Director 224-36-6016
Usual Residence of Decedent Nov.12, 1929 Radford, VA with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits tam 27 Is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examiner mast be noticed at 1 X Yas 2 □ No Directo Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1124 Kennebec Street , Apt. # 3 20745 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours effer death v Department of Health end Mental Hygiene. Important: If Itam 27 Ia marked other than "natural", or Itama 234 any Injury or other traumatic event, and Medical Examples in Funeral 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) Cottege (1-4or 5+) 12th Cook Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Reed Hattie Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. fnforment's Name/Retetionship (Type, Print) 6428 North Capitol Street NW Washington DC 20012 Oscar R. W. Lee - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donatton 5 ☐ Other (Specify) 8-7-00 Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licansee 4217 9th Street N.W. Washington DC 20011 Mars 23a. P. 11. Inter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, short, or heart failure. List only one cause on each line. **Physician** Myocardial Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner and I-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or thjury that initiated events resulting in death) Last physician a Physician/Medical Due to (or as a consequence of): USB Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributa to the causa of death? Me to sto lic Breast Conser, Liver Conser 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Bone Concer, Preumonia 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 25 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 28a. Dete of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how Injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 Yes 2 No 24 hours efter death. Funeral Director: Af 2 ☐ Accident 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of fnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier nego tump P37066 07-31-2000 7emple Hills, mo 20748 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

6

Baltimore, Maryland 21215-0020

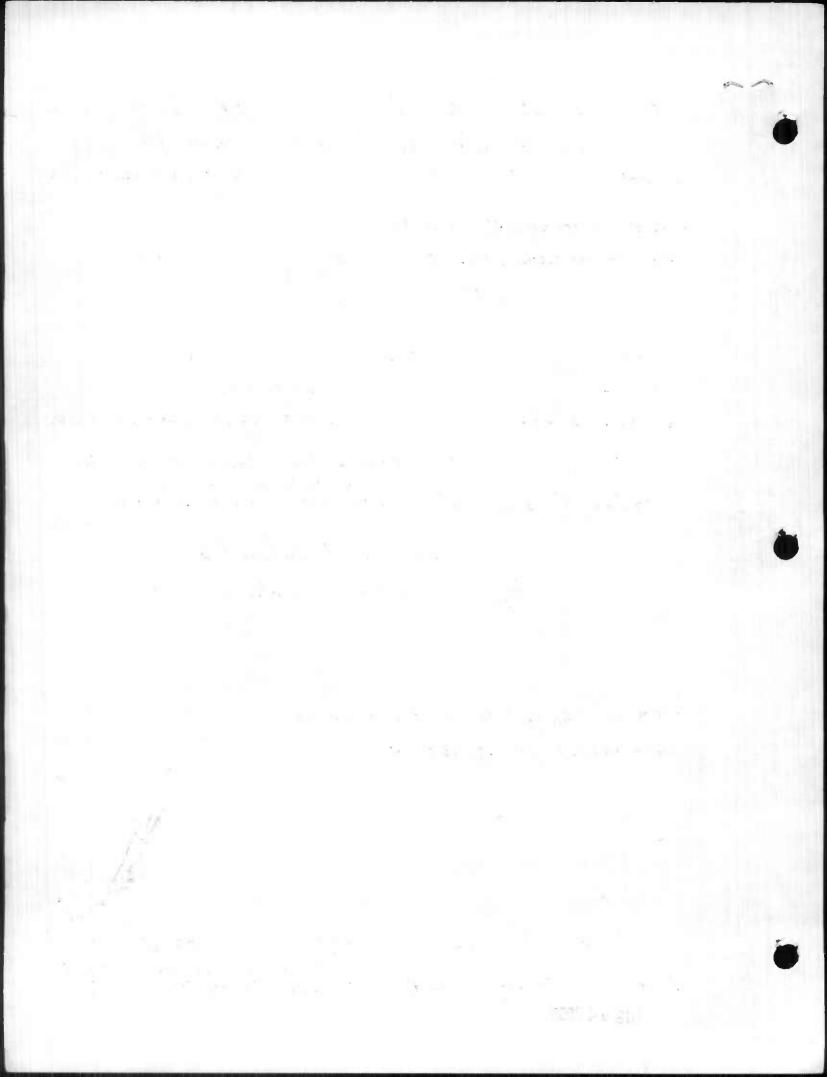
Division of Vital Records, P.O. Box 68760,

Registrar

30. Name and address of person who completely a survey of the chi. 7. Opaigheogu, m. 0.

31. Date filed (Month, Day, Year)

ALIC 0 4 2000



Troy Kenneth Richardson

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State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #23 PART I, PER MEO G786 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** TROY KENNETH RICHARDSON 09:27 A.M. 28 2000 July /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Rear of 135 Crescent Road Greenbelt If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 22 Yrs. Birthplaca (Stala or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F Months Days 577-02-4405 Oct.30,1977 Washington, Director Usuat Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow notified at 1⊠Yes 2□No Directo Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? than "natural", or items 23s or the Medical Examiner must be items 23a or 7214 Patterson Street 20706 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent'a Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Trainee (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Private Air Condition Repairman tygie 18. Mother's Name (First, Middle, Maidan Surnama) 17. Father's Nama (First, Middle, Last) 2 should be fi and Mental H le merked Kenneth S. Richardson Betty Finley 10 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other treun Kenneth S. Richardson/Father 7214 Patterson Street, Lanham, Maryland 20706 20b. Place of Disposition (Name of cematery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 08705 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removat from State Walnut Grove Church Ceme. 2000 4 ☐ Donation 5 ☐ Other (Specify) Warrenton, N.C. 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licens ore 7474 Landover Road, Landover, Maryland 20785 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** GUNSHOT WOUND TO HEAD Immediate Cause (Final disease or condition resulting in death) ilización: Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Undarlying Cause (Disease or Injury Due to (or as a consequence of) and Box 68760, attending physician that initiated events resulting in death) Last Due to (or as a consequence of): es the P.O. 23b. Did tobacco uss contribute to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed this certificate has Physician: Be 25. Was cese referred to medicel 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Scene 2 1X Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury Counter St. Time of (Month, Day Year) Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attending 5 Pending investigation 1 Natural Suger 504 29-00 Shot OB49 M after death.

Director: Af
d in by the fu 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State)
135 Crusert Rd 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Van - parking lot 135 Cresent Rd

1☐ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

**EXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifiar 18 O.C.M.E. July 29, 2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) JUNIO 100 le 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 22. Registrar's Signature State AUG 0 2 2000

Registrar

Santa No

State of Maryland / Department of Health and Mental Hygiene 0 26 147

Carles Con				Certifica	te of De	eatn	F	leg. No.	
District	1. Decedent's Nama (First, Middla, I		0				2. Date of Dea	-	3. Time of Death
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Examiner	4a Facility Name (If not institution, g						Location of Death		
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Funeral Director	5. Social Sacurity Number N/A	Sex 7. Aga ((In yrs. last birt	Yrs. If Undo	er 1 Yaar If	Under 24 Hrs. lours Min.	8. Data of Birth (Month, Day JULY /	7 7000	Birthplace (State or Fore MARYLAND
	Usual Rasidence of Decedant								
ified at	MD 10b. County PRINCE	GEORGE'S	NEW C	n or Location	ron				10d. Inside City Lim 1 💆 Yas 2 🗆 i
at be notified at Director	10a, Street and Number 6130 85th Ave	nue			ip Code 20784			10g. Citizen of V U.S	
af, or here 23. Examiner must by Funeral	11. Manifal Sfatus 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yas 2 No If Yes, Giva Yaar or Datas:	er in U,S.	13. Was Dec If Yes, sp		nic Origin? (S Maxican, Puert pecify:	pecify Yes or No- o Rican, etc.)	14. Raci Blac Specify	e - American Indian, kk, Whita, atc. Black
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Mental H inked off afte ever To Be	Roger Rosale					Arlene			
27 is ma c traum	19a. Informant's Neme/Raletionship Arlene Washingto			Mailing Addras			ral Routa Numbe Carroll		Stata, Zip Code) 20784
at of the till flam by or othe	20a. Mathod of Disposition 1 Burlal 2 Cramation 3 4 Donation 5 Other (Spec		cematar	Disposition (Nerv. cramatory or of Heav	othar place)	1	Date 7-29-00		City or Town, State
Osparmi importar any injur once.	21. Signature of Function Service Lice			22. Nama a	and Address o		B. Jenki Landover	ns Fune:	ral Home
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ng physician and s as the burial-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last	b. RESPIR	HTORS	consequence of consequence of	LURE):	SECO	PAR d Pro	TOAB	DUE
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Day Year Month JOHNNIE REED July 01:58 26 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death MEDICAL CENTER BALTIMORE BALTIMORE CITY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 239-18-3772 1 M 2 F Months December 4, 1920 North Carolina Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location YOYes 2 No D.C. N/A Washington 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? 20003 U.S.A. 1007 4th Street 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Gyes 2 No If Yes, Give Year or Dates: 1943-51 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Cook Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosie Taylor Emose Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Reed - Wife 1007 4th Street S.E. Washington DC 20003 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Quantico National Cem 8-1-00 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, D.C. 20011 or the mode of dying, such es cardiac or respiretory arrest, Interval Between Onset and Death and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es mock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis 2 days Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician/Medical Examiner

Be Completed by

edical Certification: To

Physician

/Medical

Examiner

10a. State

Funeral

Director

or items 23a or 28a-f ahow

Funeral Director

Be Completed by

death with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Itam 27 is merked other than "natural", or then any Injury or other traumetic available.

Baltimore, Maryland 21215-0020

pital or Attending Physician: The law requires that the death certificate be associted ours after death.

were Infector: After this certificate has been signed by the attending physician and filled in by the funcial director, page 2 should be deteched for use as the burst-transit Division of Vital Records, P.O. Box 68760, To the Hospital o within 24 hours af To the Funeral Di completely filled in

Part II. Other significant conditions of Diabetes Mellit		sulting in the underly	ing caus	se given in Part I.		contributs to the cause of death?
Hypertension				44	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
					1 XYes 2□N	o 1 ☐ Yes 20XNo
25. Was case referred to medicat examiner?				26. Place of De	eath (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other: 4 Nursing	Home 5 ☐ Residenca 8 ☐	Other (Specify)
27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how Injury oc	curred
3 Suicide 6 Could not be determined	28e. Placa of Injury - At h building, etc. (Speci	nome, farm, street, fa	ctory, o	ffice	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,
29a. Certifier (Check only one) Certifying Phy	raician: To the bast of my known iner: On the basis of examine and manner stated.	owledge, deeth occur ation end/or investiga	rred at t	he time, date and plac my opinion, deeth occ	ee, and due to the cause(s) and curred at the time, date and ple	manner as stated. ca, and due to the cause(s)
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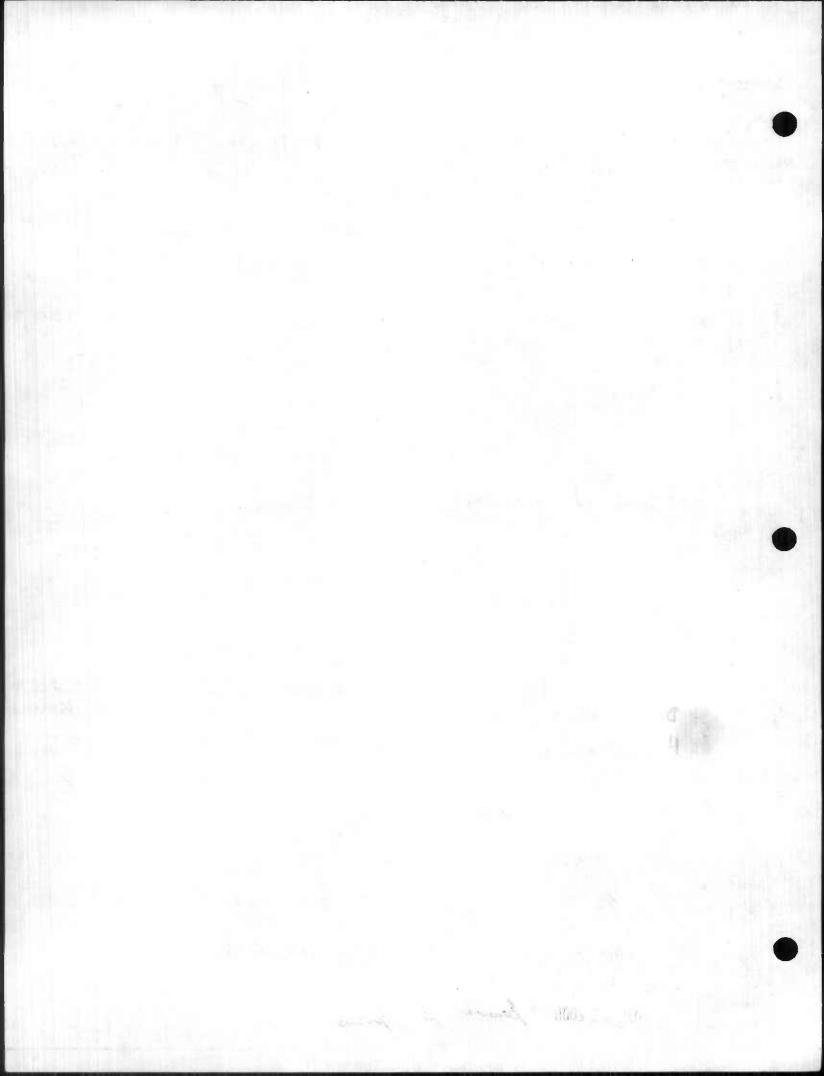
address of person

410 W. Lombard 32 Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

Au 4176435G 13/23 July 26, 2000

Baltimore, MD 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 0820 **EDWARD** RIFENBERG AUGUST 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BERLIN
If Under 1 Year If Under 24 Hrs. ATLANTIC GENERAL HOSPITAL WORCESTER Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Hours 153M 2□ F Yrs 094-20-3769 NY Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No NY Director ALBANY COHOES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 JAMES STREET 12047 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 (MYes 2 □ No If Yes, Give Year or Dates: WW I 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRINTING 12 PRINT SETTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HAROLD E. RIFENBERG VIOLA HINES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) HELEN RIFENBERG JAMES ST., COHOES, NY, 12047 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 Semoval from State 4 Donation 5 Dother (Specify) MEMORY GARDEN COLONIE, NY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD, 23a. Pent. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting In deeth) ASCVD Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence ot): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were eutopsy tindings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Injury et Work? 5 Pending investigation 1 Wetural 2 Accident 1 Yes 2 No 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homiclde 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certilier 08-06-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 SLOW ST SNOW HILL, Mb. 2185 WEETH AUG 0 6 32. Registrar's Signature 31. Date tiled (Month State

Registrar DHMH 16 Rev 6/95

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Funeral

Director

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Pages 1 and 2 should be nent of Health and Mental

altimore,

Department of Health Important: If Itam 27 I

Physician

/Medical

Examiner

The law requires that the death certificate be assecuted

or Attending Physician:

death. after death Director:

To the Hospital or within 24 hours at To the Funeral D

After this

P.O. Box 68760.

of Vital Records,

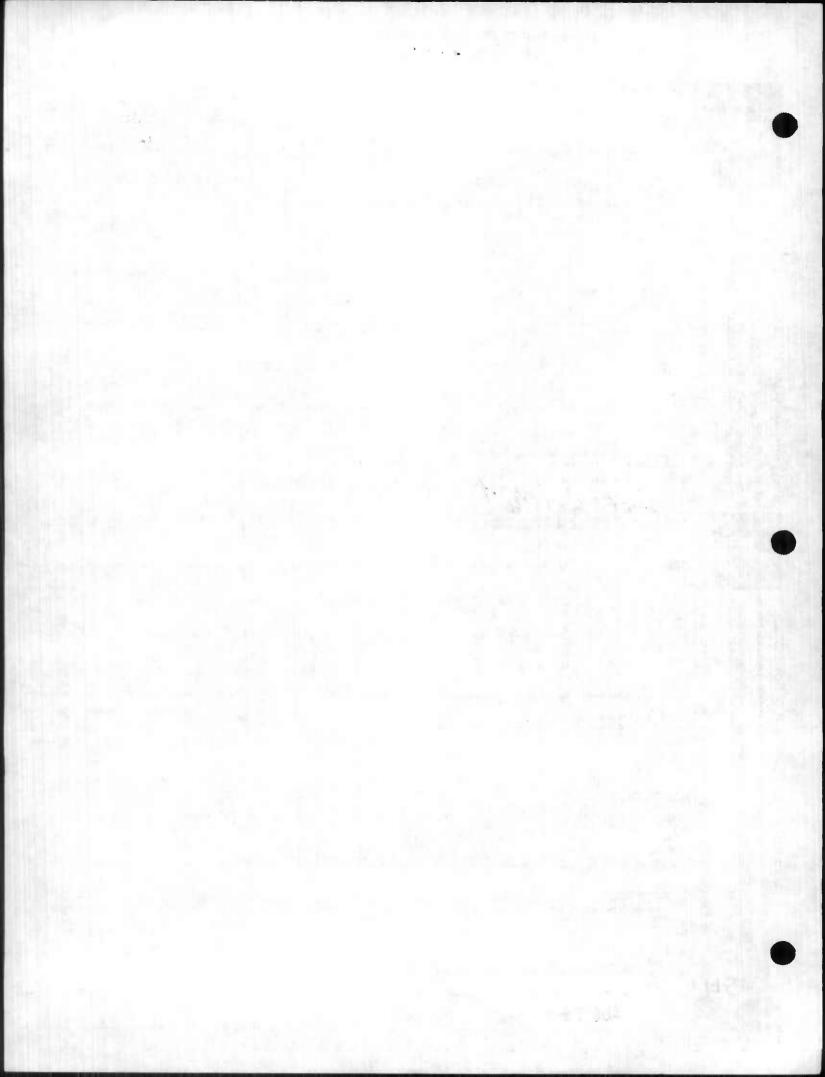
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injury or

Maryland 21215-0020

Edward

Rifen



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AUGUST FWEL 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give str 4c. County of Death Examiner HOSPITA LNION CECIL # Under 1 Year | If Under 24 Hrs. | 8 Age (In yrs. last birthday) 85 Yrs. 5. Social Security Number **Funeral** 12M 2□ F Days Hours **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 PYes 2□No Funeral Director MARYLAND ECIL 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 6 23a 4.5, 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☑Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items filed within 72 hours after 1□ Yes 21 No Baltimore, Maryland 21215-0020 Be Completed by WHITE 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) MEDICAL COSP. Elementary/Secondary (0-12) 12 other ! 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health end Mental IN FORMA TION RAY ALICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vi: If Nem 27 is n Judith ANNAPOLIS MD-21403-1651 DEVON COURT 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL permit. Page Department of important: If any injury or ARLINGTON 4 ☐ Donation 5 ☐ Other (Specify) A49.30,2000 21. Signature of Funeral Service Licensee Klioun Gee FUNCIAL HOME 259 EMAIN ST. ELLOWIND 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examine Hospital or Attending Physician: The lew requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 27. Menner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Yes 2 No within 24 hours after deeth. To the Funeral Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number 123322 Jackder- S. MD 8.6.2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elkton MD 21921 S. S. SACHDEN MD. 118 North St Swite 3B, 31. Date filed (Month, Day, Year) 32. Registrar'a Signature

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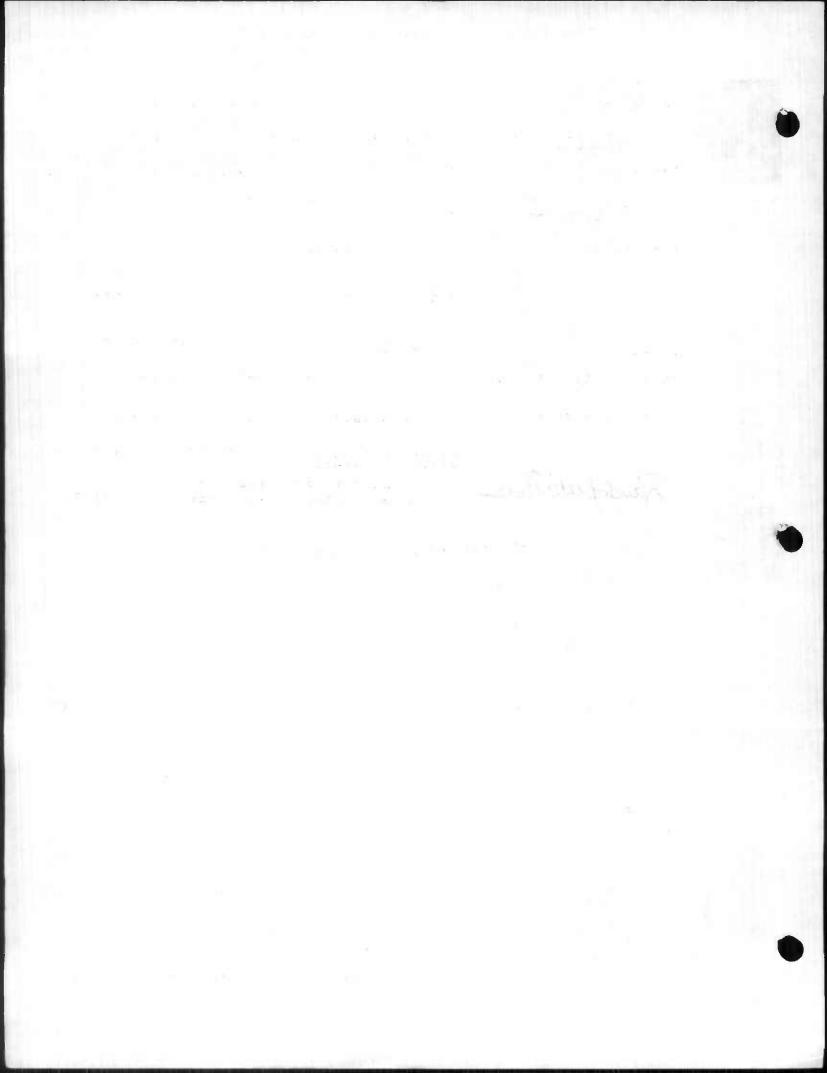
State Registrar

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amend	ite	m 26 per verbal response G786 8		Certificate o		Reg. No.	0 26151
Physic /Medi		Frederick Ellis S	pence,	Sr.	J u ^N .	-	3. Time of Death 6 AM
Examir	ner	4a. Facility Name (If not institution, give street and nu Talbot Hospice Hous		Cynwood	4b. City, Town, or Location Easton	of Death 4c. County Talk	
Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F	7. Age (In yrs. last b	oirthday) If Under 1 Yes Months Dey	s Hours Min. (A	ele of Birth Month, Day, Year) r • 20 , 1916	9. Birthplace (State or Foreign Country) M.d.
how		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location			10d. Inside City Limits
h the Ma r 28a-f s	Director	MD Caroline 10e. Street and Number	Dent	10f. Zip Code)	10g. Citizen of	1 ☐ Yes 2\(\tilde{\Lambda}\) No What Country?
eath with		116 Siesta Drive	edent Free In LLC		629	US	
d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. The merked other than "netural", or flams 23a or 28s-f show treumstic event, the Medical Enamine must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Dec Armed For Interest For Inter	2 No 1941-	15. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Specify Yuben, Mexican, Puerto Rican Specify:	, etc.) Bla	ce - American Indian, ck, White, etc. y. White
filed within 72 ho Hygiene. ther then "netui	Completed	15. Decadent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1 1 H • S • q r a d		a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti Mason	upation le during most of working red)		usiness/industry
hould be filed withing Mental Hygiene. marked other than matic event, tre Mental Menta	To Be Co	17. Father's Neme (First, Middle, Last) Edward Ellis Spence	е	M a S O II		ecca Bayr	
2 sh and is m		19e. Informant's Name/Relationship (Type, Print) Helen M. Spence			et and Number or Rural Rou Drive, De		
permit. Pages 1 and 2 Department of Haalth a Important: If tiem 27 is any injury or other trei		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State Md . H	of Disposition (Name of tery, crematory or other p Eastern Sh	ore 7/7,		City or Town, State
permit. Departminents Imports any inju		21. Signature of Funeral Service License 1100 YZ	Veter		ress of Facility 'uneral Home		1d. 21629
Dharlela		23e. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e	aused the death. Do	o not enter the mode of d	Second St., ying, such as cardiac or resp	Defice on , is	Approximete Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	DRONAR	Y ARTE	RY DISEA	SE	20 YEARS
ed sit	liner	b/_	Due to (or as a	a consequenca of):			1 YEAR
icata be executed physician and s the burial-transit	edicai Examine	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that influence events resulting in deeth) Last		a consequence of):			
death certific e attending pl od for use as f		d					
the the	Physician/M	Part II. Other eignificant conditions contributing to de	eath but not resulting	in the underlying cause	given in Part I.	23b. Did tobacco use co	ntribute to the cause of death
requires that the sean signed by hould be detact	by	HYPERTENSION				1 ☐ Yes 2 ☐ No	3 Probably 4 Chknow
aw 2 s	Completed				2	4e. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
E es		25. Was case referred to medical			00 81	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
5 00	tion: To Be	examiner? 1 Yes 20 Yoo		. Time of lnjury 28c. In			er (Specify) Hospice
To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director; After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, t ng, etc. (Specify)	farm, street, factory, offic	e 28f. Lo	ocation (Street and Numb ity or Town, State)	per or Rural Route Number,
To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai (29a. Certifier (Check only one) Certifying Physician: To the be and mani	best of my knowledg asls of examinetion a ner stated.	ge, death occurred at the and/or Investigation, in my	time, date and piace, end du oplnion, deeth occurred at t	ue to the cause(s) and me the time, date and placa,	anner as stated. and due to the cause(s)
To th within To th	Me	29b. Signature and title of cedifier			1538/5		d (Month, Day, Year)
	4	10 Name and address of person who completed cause LORAH ML PU	e of death (Item 23a)	(Type, Print)	53815 174 5 th AVE	NUE DENT	IN MD
Sta	te ar	31. Date filed (Month, Day, Year) 32.9 JUL = 7 2000		6. Some		- //20101	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) **Physician** ANNIE M. SEWARD July 30, 2000 4:00 AM /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Data of Birth (Month, Day, Year) Oct. 7, 1912 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2√ F 87 226-80-3835 Yrs. Virginia Director Usual Rasidance of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow the Medical Examiner must be notified at Yes 2□No Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with Harne 23a or 20904 11325 New Hampshire Ave U.S.A. filed within 72 hours after death 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐No If Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 ☐ Nevar Merried 2 ☐ Married Maryland 21215-0020 6 1 ☐ Yes 2 ☐ No Specify: Specify: Black A 3 Widowed 4 □ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) al Hygiene. Etementery/Secondery (0-12) College (1-4or 5+) 12th N/A Housewife traumatic avent. 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) permit. Peges 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic avent ROSs. James A. Alston Sophia Broadnax 19b. Meiling Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 11434 Stewart Lane #C-2, Silver Spring MD Mary L. Morefield - Daughter 20904 Baltimore, 20b. Place of Disposition (Name of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 8-4-00 Brentwood, MD 22. Nama and Address of Facility
Marshall's Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensae 4217 9th Street N.W. Washington, DC 20011 23a. P. J. Entar the disaesa, or complications that causad the deeth. Do not antar tha mode of dying, such as cerdiac or respiratory errest, s. c.k, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset end Death **Physician** Aro Pulmonenzy /Medical Immediate Causa (Final diseasa or condition rasulting in death) Examiner Physician/Medical Examiner Sequantially list conditions, if any, leading to immediate ceuse. Entar Undarlying Cause (Disease or Injury and The law requires that the death certificate be associ OBSTRUCTIVE PULMONARY DISCASE Box 68760. DHIC eted avants Dua to (or as a consequence of) rasulting in daeth) Last Bromy of Ait Part II. Other eignificent conditions contributing to death but not rasulting in the underlying ceuse given in Part t. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 25 No 3 Probably 4 Unknown signed by Division of Vital Records. Q 24a. Wes an autopsy performed? 24b. Wera autopsy tindings available prior to Completed completion of cause of death? certificate has 1 ☐ Yas 2 ₺ No 1 ☐ Yes 2 No or Attending Physician: 25. Was case raferred to medical axaminar? Medicai Certification: To Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this s after death.

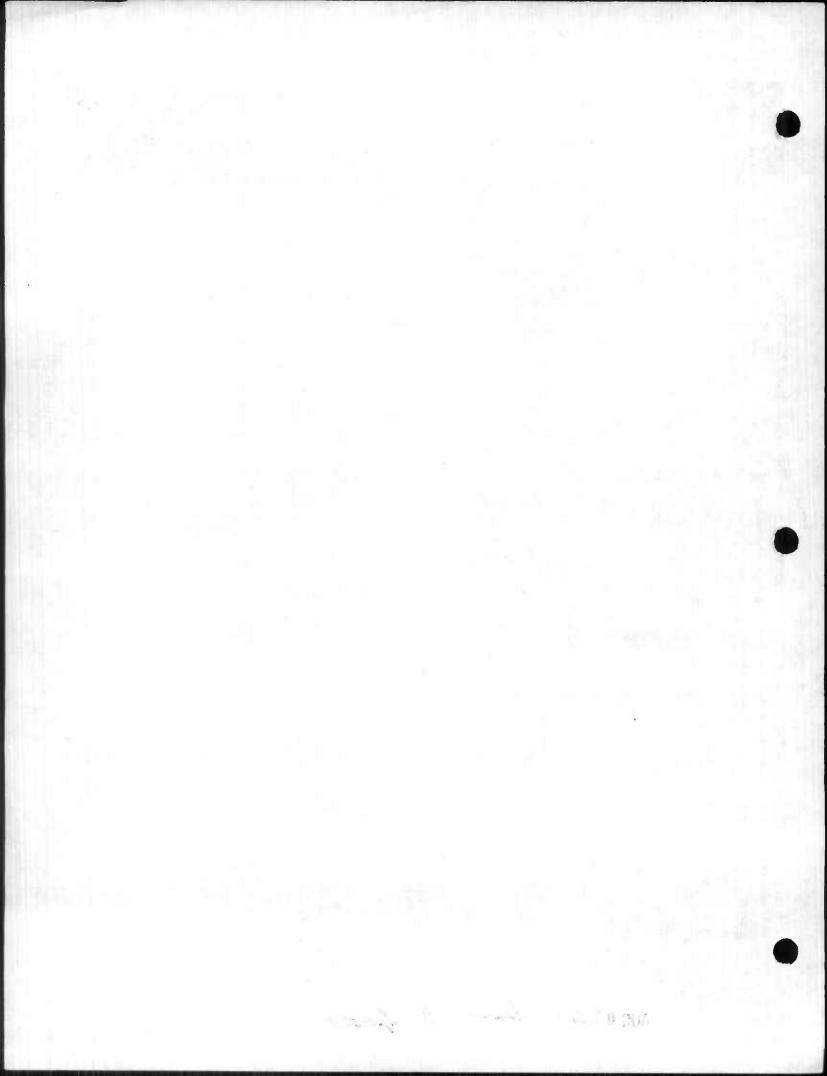
I Director: After this of in by the funeral d 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Mannar of Daath 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending Invastigation 1 Yas 2 No 2 Accident 281. Location (Street end Number or Rural Route Number, City or Town, Steta) 6 Could not be 3 Suicide 28a. Plece of Injury · At homa, farm, straat, factory, offica building, etc. (Specify) filled in by 4 Homicida To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data end place, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(a) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year) who complated cause of death (Itam 23a) (Type, Print) 30. Name and add PARKWAY GREENBELT MARYLAND 32. Registrar's Signatura 31. Data filed (Month, Day, State

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Registrar

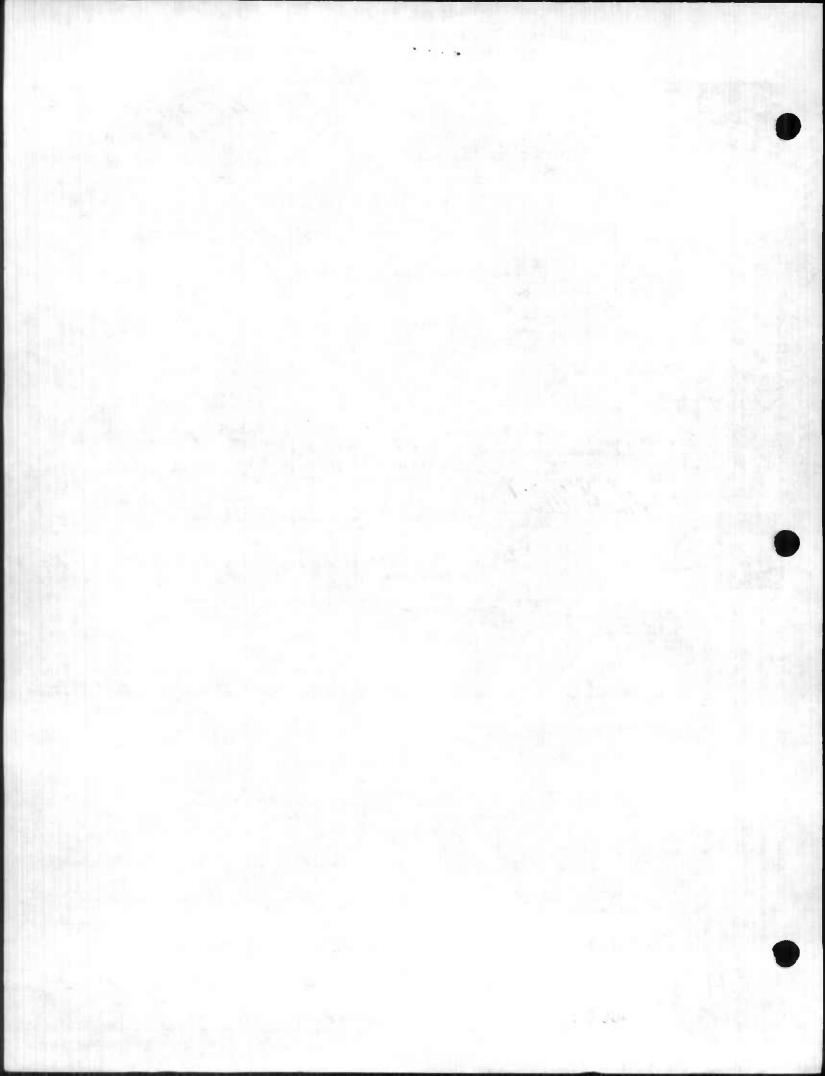
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State of Maryland / Department of Health and Mental Hygiene 00 26153

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	/Medic Examin		4a Facility Name (# PENINSUI	f not institution, gi	ive s <i>treet</i> end nu	um <i>ber)</i>			4	b. City, To		cation of Death	4c. County			
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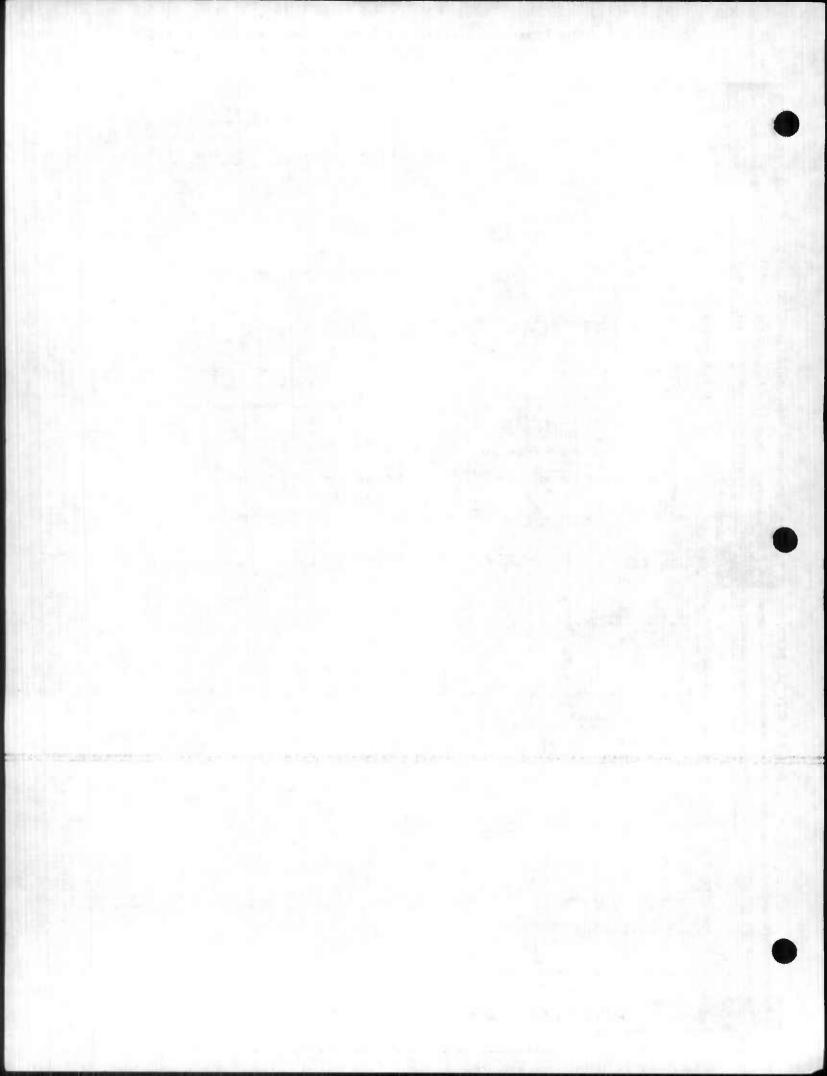
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State of Maryland / Department of Health and Mental Hygiene 00 25154

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	Physician	_	Jody Dale SPEA	RS								Month July	30, 200	Year	1322
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	Funeral	1;		6. Se	x □M 2□F	7. Age (in]	yrs. last birtho	Mont		Hours	Min.	6. Dete of Bi (Month, Di Oct. 18	ey, Year)	9. Birth	plece (State or Foreign ntry) t Virginia
	Director		236-27-6318			1	9 11					Oct.18	3,1980	Wes	t Virginia
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	the sail .		10a. State 10b. County			100	. City, Town o								10d. Inside City Limits
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	her death or here 23 siner man	5	11. Marital Status		12. Was Dec	edent Ever	in U.S.	13. Was De	cedent of H	lispanic Orl	ain? (Sp	ecity Yes or N	p- 14. Re	ce - Ameri	can Indien.
	hama hama bac.m	5	1⊠ Never Married 2 Merrie	ad I	Armed Fo	orces?		If Yes, s	pecify Cube	en, Mexica	n, Puerto	Rican, etc.)	Bio	eck, White,	, etc.
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밀	State of the state		17. Father's Neme (First, Middle, L	.ast)						18. Mothe	er's Nem	e (First, Middle	, Maiden Suma	me)	
<u>a</u>		0	Tom R. Spears,	Jr						Da	wn J	ones			
Maryland 21215-0020	2 should and Mer is marks sumstice		19e. Informent's Nama/Relationsh	ip (T)	rpe, Print)	1	19b. A	leiling Addr	ess (Street	and Numb	er or Rui	ral Route Numb	per, City or Town	n, Stete, Zij	p Code)
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00	89728		1 XXX	1	111	1100	11.6	415 H	E. Wil	son I	31vd	, Hage	rstown,	Mary	land 21740
		+	23a. Pert 1. Enter the disease, or o	compl	ications that	caused tha	iaeth. Do noi	enter the r	node of dvir	na. such es	cardiac	or respiretory	arrest.		Approximete
8	1	1	shock, or heert feilure. List of	only o	ne cause on	each line.			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,				1	Interval Between Onset end Death
ы	Physician														
	/Medicai Examiner		Immediate Cause (Final disease or condition		gu	inshot	wound	to h	ead					1	14 hrs.
		01	resulting in deeth)			Due	to (or es e co	nsequence	of):						
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oʻ.	80 G T N	Ž	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying												
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×	ding se a	3		6	d										
Bo		3			200										
o.	t the death by the atte	2	Pert II. Other significant condition	ns cor	ntributing to d	leath but not	resulting in the	ne underlyir	ng cause giv	ren in Pert	l	23b. Did	tobacco usa c	ontribute 1	to the causs of death?
<u>Ч</u>	at the lby the stack		alcohol abuse									10	Yes 20 No	3 Pro	obably 4 Unknown
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5	nequires		depression										s an autopsy	24b. W	Vere autopsy findings vailable prior to
Record	been should	Į .										pen	ormed?	C	ompletion of cause
ě	8 8 8	-													f death?
	The L	3										10	Yes 2 No	1	☐ Yes 2☐ No
Viita	Physician: The this certificate ral director, page Co.		25. Was case referred to medical examiner?							26. Place	e of Deat	th (Check only	one)		
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ō	Phy orthis eral c		27. Manner of Death		28a. Dete	of Injury	28b. Tin		28c. Injur	y at		28d. Describe	how injury occu	urred	
Division	ding far.	3	1 □ Natural 5 □ Pending 2 □ Accident investig			1th, Day Yea 29,20		:30b.		Yes 2 🖾	No	gui	nshot to	head	d
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≥			4 Homicide determine	ned	build	ing, etc. (Sp	ecify)	, эпос, тас	nory, omoa			City or To	own, State)		Maryland
-	24 hours a 24 hours a Funeral Destricted Clean Control				home										Hagerstown
	t hours	5											cause(s) and r		
	To the Hospital or within 24 hours after To the Funeral Dir completely tilled in Madical Cert	3	(Check only one) 23 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete end place, and menner stated.												
	within 2 To the comple		29b. Signeture end title of certifier		0	. /			29c. Licens				29d. Dete sign		
			Show	41	. Dit	40 711	- Ma	1	D010	062			August	1,	2000
		-	/ away w. or rough												
		1	D. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)												
		Edward W. Ditto, III, M. D., 19011 Orchard Terrace Rd., Hagerstown, Md. 21742										21/42			
	State		31. Dete filed (Month, Day, Year) AUG 0 2	20	100 32. F	Registrer's S	ignature	6	Soon	61					
	Registrar		AUG 02	4	100	Carlot I	/	- /	7000						

Registrar



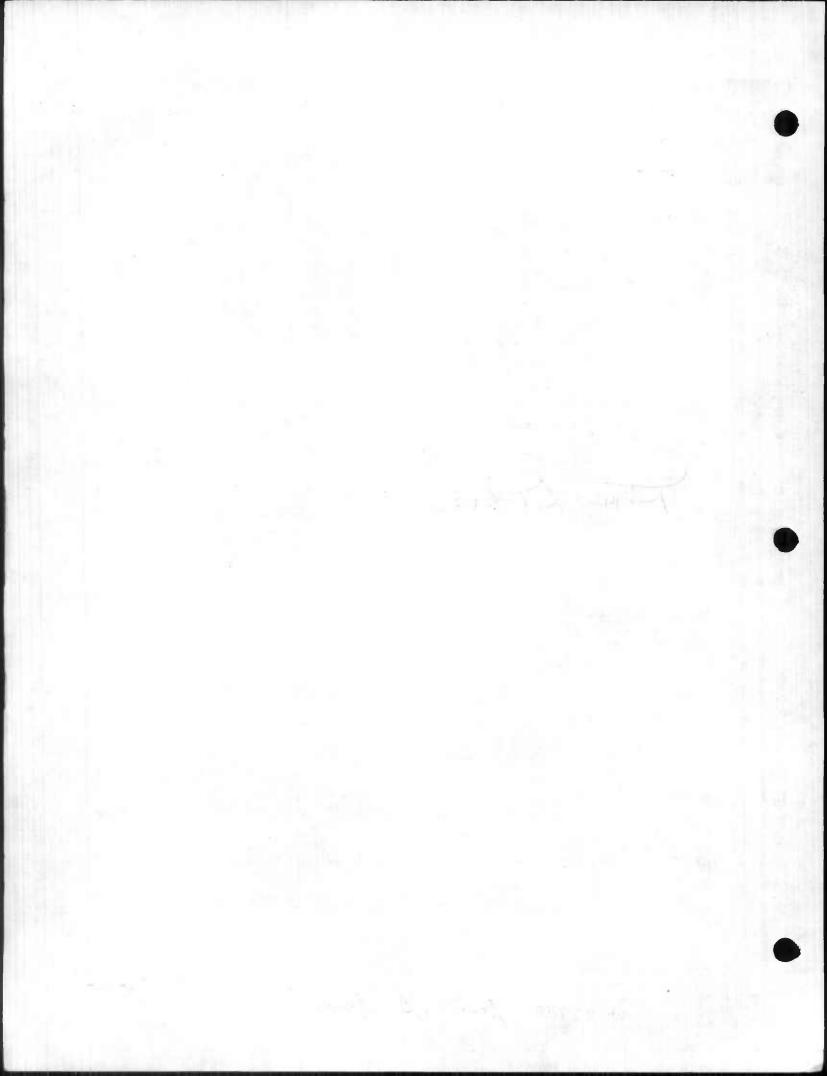
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Day **Physician** Ruth Elizabeth Smith 8:25 AM August 4, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boonsboro Washington Reeders Memorial Home 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 14, 1926 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Deys Hours Months 215-20-9878 Maryland Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Washington Smithsburg 1 ☐ Yes 2 X No Funeral Director notifie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be n 13362 Greensburg Rd. 21783 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married b 1 Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Home. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fit ment of Health and Mental H ant: If them 27 is marked off lury or other traumatic even 8 Grover C. Neikirk Ida E. Hollinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 School House Ct. Boonsboro. Md. 21713 Hazel J. Strite (Niece) 20b. Place of Disposition (Name of Long Meadow Church of the Brethren Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Aug.7, 1 Cremation 3 Removal from Stete permit. Page Department of Important: If 4 ☐ Donation 5 ☐ Other (Specify) Paramount. Md. any in 22. Name and Address of Facility Signature of Funeral Service Licens 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Jung 8 moult carrier Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be assecuted for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Pod Division of Vital Records, P.O. Box 68760, physicien Due to (or as a consequence of): signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 1 No certificata 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 1 No this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1. Natural s efter de-al Director: An-v the fu 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide filled in To the Hospital or within 24 hours of To the Funeral D Dertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certified 29c. License numbar 29d. Date signed (Month, Day, Year) D32518 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/ 301-432-2222 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State AUG 07 2000

DHMH 16 Rev 6/95

Registrar

me: Kuth Elizabeth Smit

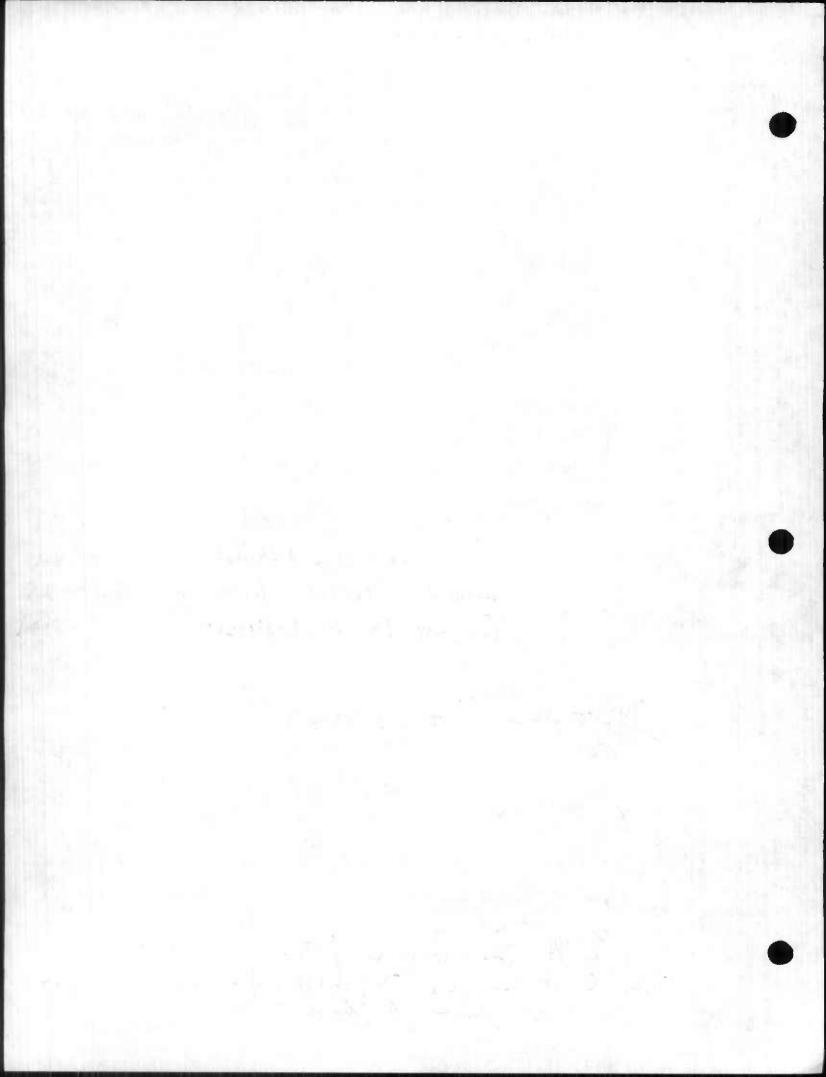


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

							0 01 1	Death		Reg. No.	00	C0100
ysician	1. Decedent's Name (First,			COLLAFI	ED				2. Date of 0	Death Day	Year	3. Time of Death
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aminer	4a Facility Name (If not inst						4		or Location of Dec		ounty of Des	
	Washington 5. Sociel Security Number	6. S	-	7. Age (In yrs. I	last hirthday	If Under	r 1 Year	Hager:			ashing	
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12	10a. State 10b. Co			10c City	y, Town or Lo	ocation						10d. Inside City Limit
rector	Maryland Was	hingt	ton	1	Hagers	town						1 □ Yes XX
	10e. Street and Number	r Dri	ive		3.77	10f. Zip	o Code	21740			of What C	ountry?
by Funeral	11. Merital Status 1 Never Merried 2 3 Widowed 4 Divis		12. Was Deci Armed Fo 1 Yes If Yes, Giver or D	2⊠ No		Was Decedif Yes, spe		spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10- 14.	Race - Am Black, Whi	erican Indian, ite, etc. white
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- L	Immediata Cause (Final disease or condition resulting in death)		o	CCTE Due to (or	r as e conse	Chur	Vari	L EC	diac or raspiretory			Interval Between Onset and Death Hauns
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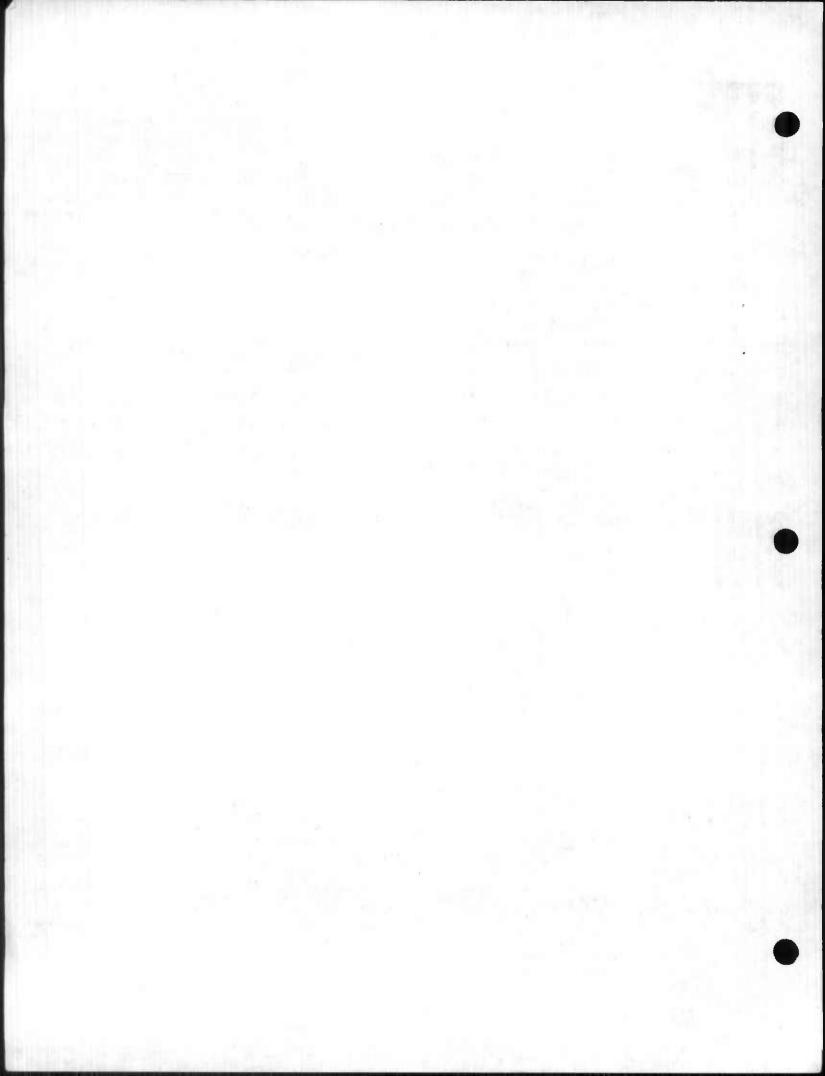
State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G786 8/28/00 yf amend item 8 per fh G787 9/26/00 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** David AUGUST 04,2000 6:20 P.M. KONNIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street end number) Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 24 Hrs. Hours Min. If Under 1 Yaar 7. Aga (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) 51 Birthplace (State or Foraign Country) **Funeral** 10 M 2□ F Months Days Hours 231-76-7716 Usual Residence of Decedent Yrs. Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Hypans, other 25s or annual other 25s or annual be notified at want, the Medical Examiner must be notified at Chase Ci Mecklenburg Yes 2 No Funeral Director 10g. Citizen of What Country? Hashington ST USA 49 South 12. Was Decedent Evar in U,S. Armed Forces?

1 ☐ Yaa 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian, Biack, White, atc. 1 Never Married 2 Married Maryland 21215-0020 1□ Yes 2No Specify: Specify: WhITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Surveyor SURVEYING 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be and Mental Sipes is marked CONNIE Jessie Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Nama/Ralationship (Type, Print) spartment of Health as important: if them 27 is n any Injury or other to any Shoe. Chese City, VA 23924 Tonya Horne DaughTex 13785 Nuy 47 Baltimore, 20b. Placa of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 8-7-00 Chase CITY, VA Burial 2 ☐ Cramation 3. Removal from State Woodland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licenses Newcomd Allgood Davis Fun. Home Chase City 423924 Yellowing Marie Wellowing Milye of Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final DUSINGES disaese or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be asscut Box 68760. Due to (or as a consequenca of): as the 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II, Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy parformed? 2 No 1 Yes 2□ No this certificate Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Medical Certification: To COIL Director: After this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Delver OF PICK-UP IMPOUTUTE 1 Natural 5 Pending investigation 0609 1 Yes 2 No death. -4-00 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide KETUESTSTOPS I NHOUSE IS UPLY, WONTGOWING 1 Certifying Phyelcian: To the best of my knowledge, death occurred at tha tima, date and placa, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signature and title of cartifier O.C.M.E. AUGUST 05,2000 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) MARYSMAN D. Koron HW 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day, Year) 32. Registrar's Signature

Registrar

AUG 1 7 2000



State of Maryland / Department of Health and Mental Hygiene 00 26158

hysician								Death			Reg.				
hvsician	1. Decedent's Name (First, Mid	idie, Last)	10-01							2. Date o		0	V-1-	3. Tin	ne of Death
	MARIE SNY	DER								JULY		Day 2000	Year		7AM
/Medical	4a Facility Name (If not institut		reet and nur	mber)				4b. City, To	wn, or Lo			4c. County	of Death	1	7 711 1
xaminer	GENESIS ELDER			CREEK										T7T	
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	19a. Informant's Name/Relatio	nship (Type	e, Print)(H	IISBAND'	19b. Meilir	ng Addres	s (Street	and Numb	er or Run	al Route N	ımber, Ci	ity or Town,	State, Zip	Code)	
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ician	shock, or heart failure. Li	ist only one	cause on e	ach line.											Between and Death
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niner	disease or condition resulting in death)	8.		-/ / R.L.	- U	MINI	151						1		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** John B. Shirley 4b. City, Town, or Location of Death 2000 26. 10:25 AM /Medical 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 1223 Van Buren Dr. Annapolis
If Under 1 Year | If Under 24 Hrs. | Anne Arundel 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours Min. 100 M 2□ F Yrs. 85 Director 579-52-8446 August 14, 1914 Missouri Usuel Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examiner main be notified at 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1223 Van Buren Dr. 21403 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus e filed within 72 hours after Il Hygiene. other than "natural", or its No light of the l 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) t6a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Captain United States Navy permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important. If New 27 is marked other any Injury or other traumatic event anse. 17. Father'a Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 98 George A. Shirley Louella M. Grant 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Evelyne Shirley/wife 1223 Van Buren Dr. Annapolis, MD 21403 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 20e Method of Disposition 1 Buriet 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) Fort Lincoln Crematory 7/31/00 Brentwood, MD 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. 21401 Annapolis, MD Approximate Interval Between Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Physician Immediete Cause (Finat diseese or condition resulting In death) /Medical Waldenstroms Macroglobulinemia 2 years Examiner Due to (or as e consequence of) Examiner sician and burial-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): be axecu physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of) signed by the attending of the detached for use as Division of Vital Records. P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Coronary Artery Disease þ 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Was en eutopsy Completed **Page** 1 ☐ Yes 2K No 1 ☐ Yes 2 ☐ No certificate Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpetient 3 DOA this 28c. tnjury at Work? To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification: Neturel
2 Accident 5 Pending Injury 1 Yes 2 No investigetion 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and plece, end due to the ceuse(s) and menner stated. 29e. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certific July 28, 2000 010/05/742 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Dr. Jon Hopkins Bethesda Naval Hospital 8901 Wisconsin Ave. Bethesda, MD 20889 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State ourse

DHMH 16 Rev 6/95

Registrar

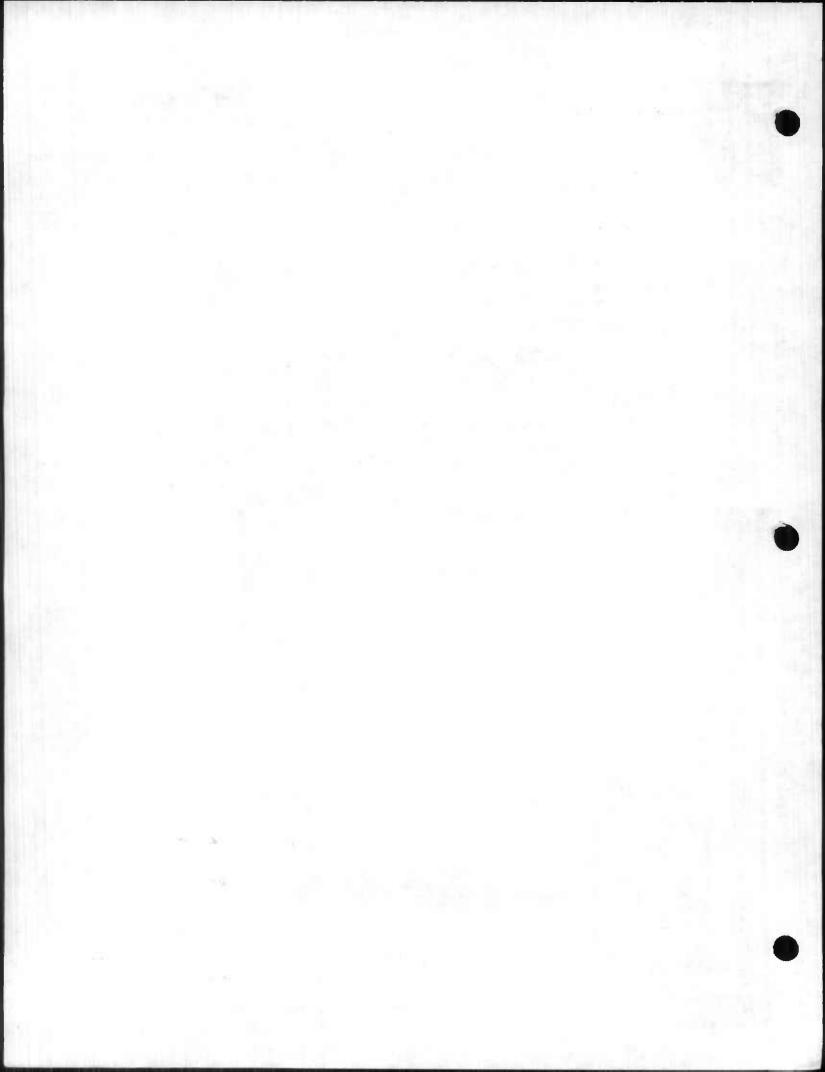
State of Maryland / Department of Health and Mental Hygiene

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Physician	Patricia Ann	Spies								AUGUS	т ов,	2000	11:41 P.M
/Medical Examiner	4a Facility Name (If not institute 29744 APPL)	ion, giva street e	end number)				4	ib. City, To		ocation of Deeth		y of Deeth	
Funeral	5. Social Security Number	6. Sax	7. Ag	ge (In yrs. last I	birthdey)		r 1 Year	If Undar		8. Date of Birt (Month, De	h	9. Birthp	Nece (State or Foreign
Director	215-62-0418 Usual Residence of Decedent	1 M 2	X F	47	Yrs.	Months	Deys	Hours	Min.	June 1	7,1953	Mary	
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sician: The law requires that certificate has been signed be irector, page 2 should be delt by PI										24e. Wes	en autopsy	24b. W	ere autopsy findings
v requir										parfo	rmed?	co	mpletion of cause
The law requires to be a sate has been spage 2 should													death?
i: The li											res 2□No	1]	Yes 2□ No
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A Sign F	X		1 LI Inpatie			1 3 D	OA	4 LI N	ursing Ho	me 5 Resident			SCENE SCENE
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be or Attending P is after death. In Director: After the in by the funers Certification:	2 Accidant inve	stigetion &	3-3-21		Know			Yes 2	No				
or Attend after death Director: / s in by the f	4 Momicide dete	mined 28a	. Pleca of Inj building, et	jury · At home, c. (Specify)	ferm, stre	eet, fecto	ry, office			City or To	on, Stete) 29	744 /	Apple drive
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within To the comple	E 29b. Signetura end title of certifier 29c. Lican										29d. Date sign	ed (Month,	Dey, Year)
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,	30. Nama and address of parson who completed cause of deeth (Itam 23a) (Type, Print)												
				Dr.			enn (Stree	t. R	altimor	e. Marv	land	21201
	Stephen S		dentz	77		4	1	4	-, D	THE WALL	, rately		
State Registrar	31. Dete filed (Month, Day Ye	7 2000	32. Hegiste	Signature	1	7.	200	us					

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Red No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6, 2000 ANNIE BEATRICE WOODLAND THOMAS Aug. 6:56pm /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata Charles If Under 24 Hrs. B. Dete of Birth (Month, Day, Year)
JAN . 11, 1935 5. Social Security Number 6 Sex If Under 1 Year 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1□M 2K F Days Months MARYLAND Yrs. 213-34-0829 65 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 11808 OAK MANOR DRIVE 20601 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 D No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) HOMEMAKER HOMEMAKING 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be FRANK WOOD CARRIE WOODLAND WOOD 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MARY
BERNICE GREENFIELD / DAUGHTER 3432 WICHITA PLACE #E, GREENSBORO, NORTH CAROLINA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removel from State MARYLAND VETERAN CEM. 8/11/00 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility THORNTON FUNERAL HOME, P.A. totax 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate Approximete Interval Between Onset end Deeth HERD SCLEROTIC HEART distace Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? NSION 1 Yes 2 No 3 Probably 4 Unknown p Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to ARTERY MISGASS completion of cause of death? 2)2(No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2QRo Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 1 DiNatural 28c. Injury et Work? 26d. Describe how injury occurred 5 Pending investigation 1 TYes 2 No 2 Accident 3 ☐ Suicide 6 Could not ba 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Dete signed (Month, Day, Year) au D - 444362000

State Registrar

Ashvinkumar

31. Date filed (Month, Day, Year)

Funeral

Director

the Maryland

permit. Peges 1 and 2 should be filled within 72 hours after death with the Marylan Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show such injury or other traumstic avent, the Medical Examples must be notified at pages.

Physician

Examiner

/Medical

physician the burial

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24 hours after deet Funeral Director:

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Hospital

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Baitimore,

Box 68760.

P.O.

Records,

Division of Vitai or Attending Physician:

The law requires

DHMH 16 Rev 6/95

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Industrial Park Dr. Waldorf, MD

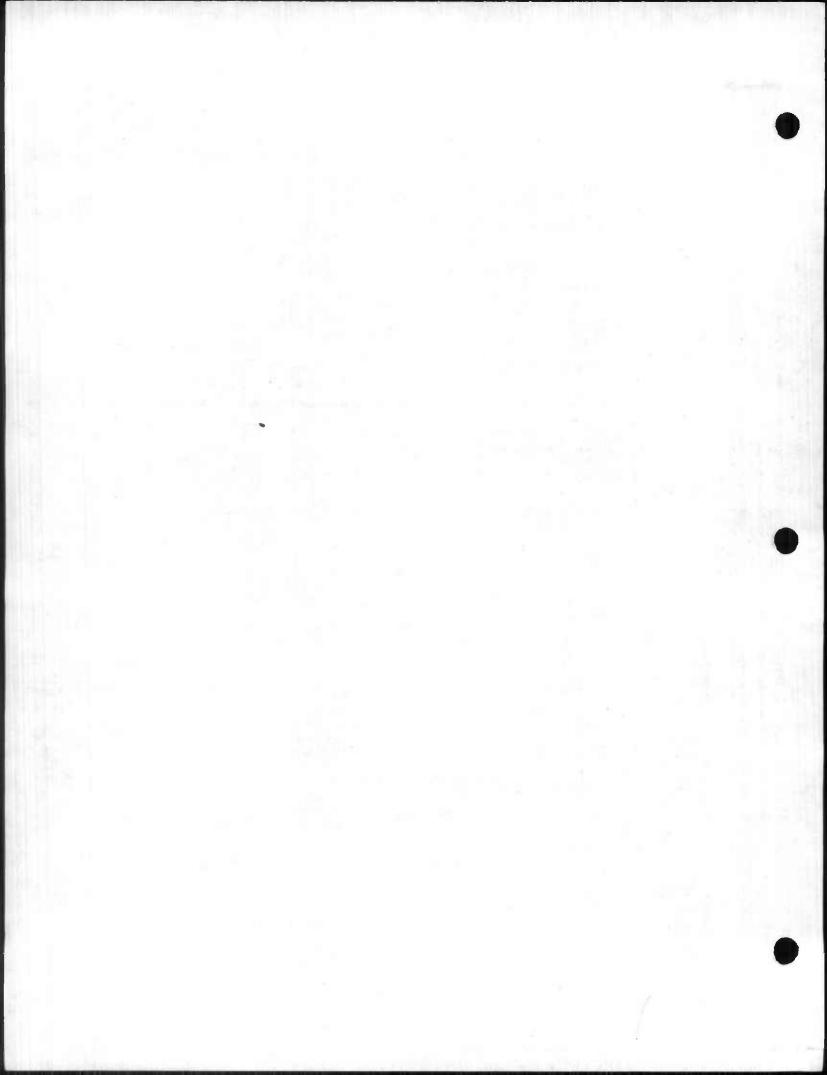
20601

of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 8 2000 >

Patel, M.D.

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 00 26 62

			Otate of Iviaryia			of Death		Reg. No.	3 6	
Physici	30	1. Decedent's Name (First, Middle, Las	(1)				2. Dete of De Month		Year	3. Time of Death
/Medic	_	Gloria Ann Turr	ner				Augus		2000	9:45PM
Examin		4a Fecility Name (If not Institution, give	street and number)			4b. City, Town, or		th 4c. County	of Death	
		Holy Cross Hosp	oital			Silver S	-		ontgon	ery
[♭] Funeral Director		3/8-32-0991	T44 000 5	. last birthday) 75 Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.	8. Dete of Bi Month, Di May 18	rth Year) ay. Year) 1925	9. Birthple Counti Wash	aca (State or Foreign ny) 1., D.C.
with the Maryland a or 28a-f show Lbe notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo		ity, Town or Lo		Silver Spri	ng		10	d. inside City Limits
er death with the Maryla Herra 23e or 28e-f shor net must be notified at	al Director	10e. Street and Number 9246 Three Oak	Dr.		10f. Zip Co	de 20901		10g. Citizen of V	What Counti	•
	by Funeral	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 24 No if Yes, Give Yeer or Dates:			of Hispenic Orlgin? (S Cuban, Mexican, Puerl No Specity:	pecify Yes or No o Rican, etc.)	o- 14. Rec Blac Specify		n Indian, Ici Prican Lian
Maryland 21215-0020 sd 2 should be filed within 72 hours after th and Mental Hygiene. Tr is merited other than "netural", or the traumetic event, the Medical Exercine.	npieted	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)			ccupation one during most of wor etired)		16b. Kind of Br		
Nagara	Сотр		5+	Tea	cher -	Administra	tor	Gov	vernme	nt
/land	To Be	17. Father's Neme (First, Middle, Last) Orlando E. 1	Hi11				me <i>(First, Middle</i> Ina Evan	e, Maiden Suman IS	ne)	
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Baltimore, amit. Pages 1 ar appartment of Hea mportants if Nems my injury or othe notes		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify	Removel from State	Place of Dispo cemetery, crer	natory or other	piace)	Date 3/8/2000	20c. Location -		
Balti pemit. Departm importa any inju		21. Signature of Foneral Servica Licen		7 22		ddress of Facility G		Funeral WashI		20019
Dhusialan		23a. Par Enter the disease, or composhed of heart failure. List only	plications that caused the decore cause on each line.	ath. Do not ent						Approximate Interval Batween Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Myocardi	Introduction of	110000000000000000000000000000000000000	Links				Days
-	er.			(or as a consec						V
cuted	Examiner	Sequentially list conditions,	b. Coronary Due to	(or as e consec		se			1	Years
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death certifies attending	clan/									
IS, P.O. BOX es that the death cert igned by the attendin be detached for use	Physician/M	Part II. Other significant conditions or	ontributing to death but nof re	sulting in the u	nderlying caus	e given in Part I.		I tobacco uss co I Yss 2□ No		the causs of death?
cord requir been s should	Completed by							s an autopsy formed?	ava	re autopsy findings ilable prior to apletion of cause eath?
The law ate has page 2	E						10	Yes 2 No	1 🗆	Yes 2□ No
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Of VITA Physician: this certific ral director,	o Be	examiner?	Hospital: 1 (XInpatient 2[7.50/0	a 20 004	Othor			000 /0	1
OIN OF OIN OIL	tion: To	27. Manner of Death 1 Natural 5 Panding 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		how injury occur		
DIVISION I or Attending strer death. I Director: Atte d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		reel, factory, of	fice		(Street and Numb own, State)	ber or Rural	Route Number,
DIVISION To the Hospital or Attending I within 124 hours after death. To the Funerial Director: After completely filled in by the funerial process.	edical C		reicien: To the best of my kn iner: On the basis of examin and manner stated.							
vithir omp	M	29b. Signature end title of certifier		2	29c. Li	cense number		29d. Date signe	ed (Month, E	ley, Year)
)	30. Name and address of person who o	4060le	1		D0013456		Augus	t 3, 2	2000
(10)		Allen Oboler	- 8830 Came	ron St.		e 601, Silv	ver Spri	ing, MD	20910)
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	A	1					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Patricia Annette Tibbs AUGUST 01 2000 1:42 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** MALCOLM GROW MEDICAL CENTER CAMP SPRINGS PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) 1□M 2以F 579-92-4310 39 Yrs. Wash., D.C. 1961 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Addison Road 20743 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, atc. 72 hours after 1 Yas 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry g g Elementery/Secondery (0-12) College (1-4or 5+) Account Tech Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) should be Mental Wilbert Hines Clara Thompson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) important if hen 27 is a any lejury or other to 27 is a once. Michael Tibbs - Husband 1010 Addison Rd., Capitol Heights, MD 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cramation 3 Removal from State Washington National Cem. 8/7/2000 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 leon Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ar heart failure. List only one cause on each line. Approximate interval Betw Onset and Death **Physician** /Medical Immediata Causa (Final ACUTE MYOCARDIAL INFARCTION UNKNOWN disaasa or condition resulting in death) Examiner Due to (or as a consequenca of) Physician/Medical Examiner CORNARY ARTERY DISEASE UNKNOWN The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-trar Box 68760. the attending physician Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown OBESITY Aq Division of Vital Records. Be Completed 24b. Were autopsy findings 24a. Was an autopsy been svailable prior to completion of cause of death? performed' hes 1 ☐ Yes 2 No 2 X No 1 Yas certificate or Attending Physician: after death. funeral director, 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1) Yes 2□ No Medical Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending Investigation Injury 1 Yas 2 No filled in by the f 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatura and title of certifier m your Willmy GA 41380 AUGUST 01 2000 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 89 MDG / 1050 W PERIMETER RD SHAWN VARNEY, MAJ, ANDREWS AFB, MD 20762

DHMH 16 Rev 6/95

State Registrar

ORIGINAL

USAF, MC

32/Registrar's Signature

31. Date filed (Month, Day, Year)

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State of Maryland / Departr

ment of Health and Mental H	ygiene	0	0	0	-	-	
ment of Health and Mental H licate of Death	Reg. No.	U	U	2	0	6	L

				Certi	ficate of I	Death		F	Reg. No.) 6	0104
Physician	Decedent's Name (First, Middle, I Leonard At	ast) igustus	Tongue				2	Date of Dee	25, 200	OYear	3. Time of Death 07:30 A.M
/Medical Examiner	4a Facility Name (# not institution, g ROUTE #50 and				4		wn, or Loca POLIS			inty of Deeth E ARUNDEL	
Funeral Director	215-30-5225	Sex 7. A 1 1 M 2 □ F	ga (In yrs. last birl		Under 1 Yaar Months Deys	If Undar 2 Hours	Min.	Dete of Birth (Month, De) pril 1	7, Year) 1,1934		ce (State or Foreign Land
a-f ahow offed at	Usuel Residence of Decedent 10a. State 10b. County MD Prince	George's	10c. City, Town					Tadion.			d. Inside City Limits 1⊠ Yas 2□ No
with the	10e. Street and Number 3504 Edwards St	reet		101. Zip Code 20774				10g. Citizen of Wh			ry?
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od within 72 hours after death with the Mar ygiene. ygiene "natural", or leans 23s or 28s-f al t, the Wedical Experient must be northed Completed by Funeral Director	15. Decedent's (Specify only highest of Elementery/Secondery (0-12) 8th	Education trade completed) College (1-4or	5+)	Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) avy Equipment Operator				16b. Kind of Br		ustry	
Mental Hygie nrked other atic event, the To Be Co	17. Father's Neme (First, Middle, La Eli Tongue	st)		18. Mother's Neme (First, Middle, Meiden Sumen Katherine Hopkins					10)		
h and h and T la ma	19e. Informent's Neme/Reletionship Matilda R. Tongu			Address (Street Edwards				or, City or Town, lale MD			
mt: # lb	20a. Method of Disposition 1 2 Burial 2 Cremetion 3 4 Donetion 5 Other (Special Control of the		1	y, crame	on (Neme of lory or other plea orial Me			Dete 31-00	20c. Location -		
permit. Departit Importa any inju	21. Signature of Funerel Service Lice	exice Licensee 22. Neme and Address of Facility J.B. Jenkins Funera 7474 Landover Rd Landover MD 20785								Home	
eath certificate be assouted attending physician and for use as the burial-transit clar/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of):										
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or Attending Physics death. Director: After this is in by the funeral direction: To ertification: To	27. Menner of Deeth 1	28a. Dete of In (Month, p) be 28e. Place of Ir	ital· Other:			No 1	ing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred DRI TRUCK WHICH STRUCK			IVER OF CADUMA MOHISPATH	
Hospi 24 hour Funer (tely fill		Physician: To the best aminer: On the basis and menner s	of examination en								
To the complete complete Mec	29b. Signature and title of certifier	1. 0	Inio.		29c. Licans O.	c.M.E			29d. Date signe JULY 26		
State Registrar	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) MARY G-MPPUL MD. 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month/Day, Year) 32. Registrer's Signature							21201			

Registrar DHMH 16 Rev 6/95

NULTER STATE

State of Maryland / Department of Health and Mental Hygiene 00 26165

			Certi	ficate of	Death		Reg. N	lo.		
I. Decedent's Name (First, Middle, Las						2. Date Mont		ay	Year	3. Time of Death
		orne					31, 2	2000		10:20 A.M
		In vrs last hirt	hday	If Under 1 Year						
577-96-7763			N			din. (Mont	.17,19			ce (State or Foreigr y) and
Oe. State 10b. County	1	Oc. City, Town	or Local	tion					100	d. tnside City Limits
Maryland Prince C	Georges	Brandwi	ne							1 ☐ Yes 2次 No
	Rd., Box 43	11		10f. Zip Code 20613					hat Country	y?
1. Merital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. Wa	s Decedent of I	Hispanic Origin an, Mexican, P	? (Specify Yes	or No-			
1 ☑ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:									
15. Decedent's Ed	lucation de completed)	16a.	Deceden (Give kin	nt's Usual Occu	pation during most of	working	16b.	Kind of Bu	siness/Indu	stry
Elementary/Secondery (0-12)					rd)	30	P1	umbin	ng	
								n Sumame	9)	
	Type, Print)	19b.	Mailing	Address (Stree	t and Number o	r Rural Route N	lumber, City	or Town,	State, Zip C	Code)
Jetta L.Thorne/Mo	ther	38	00 0	aklawn	Rd., Ft	. Washi	ington	, MD	20744	
	Removal from State	20b. Place of cemeters	Dispositi y, cremat	ion (Name of tory or other pla	ica)	Dete	20c.	Location - (City or Town	n, State
		Cedar			-	8/3/20	000 Su	itlan	nd, MD)
· M // /	//		Geo 616	rge P.	Kalas I	Tuneral	Home,	P.A.	20745	
23e. Pert1. Enter the disease, or comp	plications that caused th	e death. Do n						, 1110		Approximate ntervel Between
net initiated events	c			nce of):		~~~				
	d		i i							
art II. Other significant conditions co	ontributing to death but r	not resulting in	the unde	erlying cause gi	ven in Part I.	23b.		/		
						24a.			com	e sutopsy findings lable prior to pletion of cause eath?
							1 Yes	ŽŤNo	10	Yes 2□ No
eveminer?					26. Plece of	Death (Check	only one)			
1 Ves 2 No	1 LI Inpatient		patient	3LI DUA	4 LI Nursi	ng Home 5x	Residenca	6 □Othe	or (Specify)	
7. Menner of Deeth 1 ☑ Netural 5 ☐ Pending	28a. Dete of Injury (Month, Day Y	(ear) 28b. T				28d. Des	ribe how in	jury occurn	ed	
3 ☐ Suicide 6 ☐ Could not be		- At home, far	m, street]Yes 2∐No	28f. Location (Street and Number		er or Rural I	Route Number,	
29a. Cartifier 12 Certifying Phy					me, date and p	lace, and due to	the cause	(s) and mai	nner as stat	ted.
	iner: On the basis of ex and manner stete	amination and								
	- 0			29c. Licen	se number	2.75	1000		(Month, Da	ay, Year)
29b. Signature and title of cartifier	NI									
1 En y	completed square of days	h (Itom 22a) C	Type D-				0/	1/200	00	
0. Name and address of person who c				int)					00	
1 En y	M.D. 111	L25 Roc	kvi1		e #209,				00	
	Re Facility Name (If not institution, given 10505 Cedarville 5. Social Security Number 5. Social Security Number 6. S. 577–96–7763 Usual Residenca of Decedent 100. State 100. County 100. Count	Re Facility Name (If not institution, give street and number) 10505 Cedarville Rd.	is Facility Name (If not institution, give street and number) 10505 Cedarville Rd. 5. Social Security Number 6. Sex 102	Securitially Name (# not Institution, give street and number) 10505 Cedarville Rd.	Table Security Name (If not Institution, give street and number) 10505 Cedarville Rd.	Secolal Security Number 6. Sex 12KM 2 F 7. Age (in yrs. hast birthday) If Under 17 year If Under 27 10505 Cedarville Rd. 100. County 100	Revin F.	Revin	Thorne Seculty Number G. Sex Seculty Number G. Sex Seculty G. Sex Seculty Number G. Sex Seculty Number G. Sex G. Sex	Thorne July 31, 2000 Secret and number 10505 Cedarville Rd. Social Security Number Total S

DHMH 16 Rev 6/95

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Physician		. Decedent's Name	e (First, Middle, L	ast)				rtificate of		2. Data of Do	Reg. No.	- Mar-	3. Time of Death
	_	William	H.		Tole	es				July	29, Da 200	O Year	14:58
/Medical xaminer	4.0	a Facility Name (II	f not institution, g	iva street and i	number)				4b. City, Town, o	or Location of Deal	th 4c. Cour	ty of Death	
		Souther	n Maryla	and Hosp	pital	L			Clinton		Princ	e Geo	rge's
neral ector		. Social Security N 579-05-6	234	Sex 1 XM 2 F		(In yrs. las	ot birthday) Yrs.	Months Days			0, 1919	9. Birth Cou Mad1	place (State or Fore ntry) SON, VA
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Ö	5			ot N	T _a y		20011				ed Sta		
(Specify only highest of Elementary/Secondary (0-12)							(Specify Yes or N		ace - Amari				
		1 Never Marri		If Yes Give		0	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 			èrto Rican, etc.)		lack, Whita	can-America
			ify only highest g	Decedent's Education thy highest grade completed) y (0-12) College (1-4or 5+)			16a. Deced (Give life.	Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of	Business/Ir	ndustry
200		twelve ye					B & C	Railro	ad Super		Priv		
Lucien			st)						ia E. Mas	•	eme)		
	1	19a. Informant's Na Mary E.			end					Rural Route Numb shington			#201
	20		cosition Cremation 3 5 Other (Special		m State	cen	netery, cret	sition (Nama of matory or other pi ceek Ceme		Date 8/3/2006	20c. Location		own, State
	2	21. Sprature of Eq			1	1.0		2. Name and Add	man of Equilibr	1			
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cian dical	lid	mmediate Cause (Final	inplications that y one cause of	at caused to each line	the death.	40	001 Benn	ing Rd.,	Stewart I NE Wash: iac or respiretory	ington,		
iner liner Examiner	lid of the country of	mmediate Cause (Final n nditions, mediata rlying injury	a b	E	Depoue to kor e	Do not ent	on Benn. ar the mode of degree of): Qe Remove of):	ing Rd.,	NE Wash	ington, arrest,		20019 Approximate Interval Between
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State

Registrar

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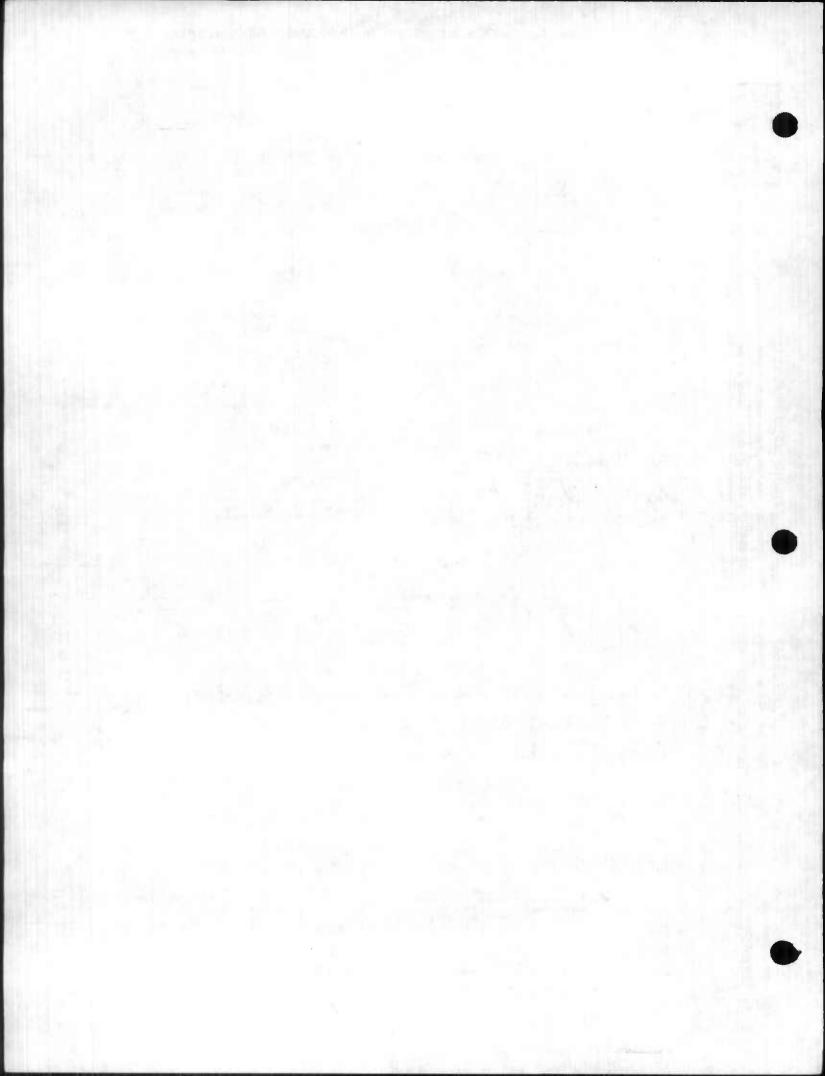
Toles, William, 7/29/00 214:58

Dr. Ali Rahimian
31. Date filed (Month, Day, Year)
AUG 0 1 2000

Registrar's Signatura

State of Maryland / Department of Health and Mental Hygiene

			Certificate o	f Death	F	Reg. No.	26161			
ALC: UNIVERSITY	Decedent'a Nama (First, Middle, Last)	7			2. Date of Dea Month		3. Time of Death			
Physician /Medical	SILAS P	OLLIV	ER		AUGUST		000 10:39AM			
Examiner	4a Facility Nama (If not institution, giva street and	d number)		4b. City, Town, or L	ocation of Death	4c. County of	Deeth			
	SUBURBAN HOSPITAL			BETHESDA		MONTGOM				
Funeral Director	5. Social Security Number 425-34-7421 6. Sex 20	7. Age (In yrs. la	Ast birthday) If Undar 1 Yas Months Dey		8. Date of Birtl (Month, Day AUG. 20	7. Year) 9 6,1929 N	Birthplece (State or Foreign Country) IISSISSIPPI			
P	Usual Residence of Decedent 10a. Stete 10b. County	10c. City	, Town or Location	E - 1			10d. Inside City Limits			
h the Marylar c 28s-f show untillised at frector	MARYLAND MONTGOMERY	SIL	VER SPRING				120 vas 2□No			
Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?				
	1902 ROSEMARY HILL VIL	LAGE #3	209	10	Ţ	UNITED ST	PATES			
5 within 72 hours after death of the state of thems 23 the Medical Examiner must completed by Funeral	1 Never Married 2 Married 14 M	Decedent Ever In U,5 d Forces? /es 2 No 1.944 s, Give 1.946 or Detes:	TO VICE OF THE	f Hispanic Origin? (Spuban, Mexicen, Puerto lo Specify	pecify Yes or No- Rican, etc.)	es or No- etc.) 14. Race - American Indian Bleck, White, etc. Specify: BLACK				
72 ho	15. Decedent's Education (Specify only highest grade comple	ted)	16a. Decedent's Usual Occ (Give kind of work dor iife. DO NOT use ret	cupation	kina	16b. Kind of Busin	ness/Industry			
ed within 7 yglene. er than 'n f. the Medi		ge (1-4or 5+)	life. DO NOT use reti	ired)						
* F & T O	12TH GRADE		SUPERVISOR S				GOVERNMENT			
Be state a	17. Fathar'a Neme (First, Middla, Last)			100000000000000000000000000000000000000		Maiden Sumame)				
Nem Menter Property out of the Property out of	CURTIS TOLLIVER				PAY TOLL:					
Middly judical of 2 should be file to and Mental Hy 7 is marked oth beautiful to a second the market event	19a. Informant's Name/Reletionship (Type, Print)		19b. Meiling Address (Street							
- 6972	NINA CHANDLER / DAUGHT			TEA TURN,			MARYLAND 2077			
Pages 1 ent of H mt. if like ry or oth	20a. Method of Disposition ★XBurial 2 ☐ Cremation 3 ☐ Removal (CO	ece of Disposition (Name of emetery, crematory or other p	place)	Dete	20c. Location - Ci	ty or Town, State			
Pag Hard	4 □ Donation 5 □ Other (Specify)		YLAND VETERAN	CEM. 8	/10/00	CHELTENHA	M. MARYLAND			
B Taget 8	21. Signature of Funeral Service Licensee	0.1	22. Name end Add	drass of Fecility						
D ESEES	THORNTON FUNERAL HOME, P.A. 12DIA C. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 200									
-	23a. Part1. Enter the disease, or complications t shock, or heer failure. List only one ceuse	hat caused the death	Do not antar the mode of o	tying, such es cerdiec	or respiratory er	rest,	Approximate			
Dhusisian	shock, or heert failure. List only one ceuse	on each line.					Interval Between Onset and Death			
Physician // // // // // // // // // // // // //	Immediate Cause (Final	0 -		٨			1 -0-			
Examiner	disease or condition resulting in death) a. Respiratory factory									
5	(.)	es a consequence of):							
executed in and ist-transit	b	neur					1 clay			
and and security	Sequentially list conditions, if any, leading to immediate	Due to (or	es a consequence of):				/			
ficate be physicie is the bu	resulting In death) Last	Due to (or	as a consequence of):				1			
	d									
et the deeth certificate by the attending pleached for use as the Physician/Mec							1			
by the sa dached if	Part II. Other eignificant conditions contributing	to death but not resu	alting in the underlying causa	given in Part I.	23b. Dld 1	obacco use contr	ibute to the cause of death?			
that the delached delached	Rough Faile	. 0			10	Yee 2□ No 3	Probably 4 Unknown			
E X 10	Tank Taute	X.L								
requir been s should	Atrial February	llation				an autopsy mad?	24b. Were autopsy findings available prior to completion of cause of deeth?			
e law hes ge 2										
					101	res 2 1 No	1 ☐ Yea 2 ☐ No			
Physician: The Physician: The Conficute of the Conficute	25. Was case rafarred to medical examiner?		1		th (Check only o	ne)				
Physic this c el direction To	1 Tes 2 PNO		ER/Outpetient 3LI DOA			dence 6 Other				
		Dete of Injury Month, Day Year)		njury at Vork?	28d. Dascribe i	now Injury occurred				
be or Attending P is after death. In Director: After ded in by the funer. Certification:	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No						
or Attending sher death. Director: After din by the fune entification	determined 400.	Piece of Injury - At hor ouilding, etc. <i>(Specify</i>)	me, ferm, street, fectory, offic ')	00	28f. Location (Street and Number or Rural Route Number City or Town, State)					
S S S S S S S S S S S S S S S S S S S										
To the Hospital or Attending within 24 hours after death or To the Funeral Director: After completely filled in by the fune Medical Certification										
within 2 To the complet		mannar stated.	100-11-	ense number		20d Data signed	Month, Day, Year)			
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	pur clean		0	03/1/	4 1	Jugust	, 6,2000			
	30. Neme and address of person who completed	ceuse of death (Item	23a) (Type, Print) 2 4	+01 Re	slave	h BC	vel.# 102_			
	JATINDER S.S.	EKHON	R	ock vill	L. M	p 20.	650			
State		2. Registrar Signet		1						
Registrar	AUG 0 9 2001) Dener	D. 10	ouks!						



State of Maryland / Department of Health and Mental Hygiene

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Physician	1. 0	Decedent's Neme (First, Middle	e, Last)						2. Date of D			3. Time of Death	
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/Medical Examiner	4a	Facility Name (If not institution	n, give street	end number)				4b. City, Town, or		- 1	nty of Deeth		
	8	820 ST. GEORG	E BARE	BER RO	AD			DAVIDSON			E ARUN		
uneral rector	2:	Sociel Security Number 15 12 1882	6. Sex		ge (In yrs. lest i	birthdey) Yrs.	Months Deys		8. Date of E (Month, E FEB.	Sinth Dey, Year) 23,1919	9. Birth	plece (State or For ntry) YLAND	
ž		uel Residence of Decedent 3. Stete 10b. County			10c. City, To	wn or Loc	cation					10d. Inside City Lir	
to to	M	ARYLAND ANNE A	RUNDEL		DAVIDS	ONVT	LLE					1 ☐ Yes 2 🗹	
red liec	10e	. Street and Number			311.230		10f. Zip Code			10g. Citizen	of What Cou	ntry?	
al D	82	20 ST. GEORGE	BARBER	ROAD		21035				UNITED	STATE	STATES	
al, or items 23s or 28s-f show Exercises must be notified at by Funeral Director		Meritei Status 1 Never Merried 2 Merri 3 Widowed 4 Divorced	An	es Decedent med Forces? 7 Yes 2 Yes, Give ear or Detes:	Ever in U,S. No 1942–43	13. W	Vas Decedent of Yes, specify Cul	Hispenic Origin? (S ben, Mexican, Puer Specify:	Specify Yes or h to Rican, etc.)	1	14. Rece - American Indien, Bleck, White, etc. Specify: WHITE		
"natural", edical Ex-		15. Decedent (Specify only highes	t's Education	oleted)	16	a Deced	ent's Usuel Occu	pation during most of wo	rkina	16b. Kind o	f Business/In	ndustry	
	E	Hementary/Secondery (0-12)	T	ollege (1-4or	5+)	life. D	OO NOT use retir	ed)		DIDIT	C LIODI	7.C	
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marked other imatic avant, To Be Co	1	ERNEST D. TUCK						LILLY	LEITCH	ie, maiden den	namo)		
merke To	-	e. informent's Neme/Relations		nint)	1	9b Mailin	n Address (Stree	at and Number or R		ber. City or To	wn. Stete. Zi	ip Code)	
27 la r trau		BETTY P. TUCKE		IFE)				E BARBER				E.MD.2103	
Important: If item 27 is marked other than any injury or other traumatic avant, the se once. To Be Comp		. Method of Disposition			20b. Piece		sition (Neme of netory or other pl		Date	T	on - City or T		
7, or		1 Burial 2 Cremation 4 Donetion 5 Other (St		al from State			TAN CREM		08-04-00	ATEVA	NDRIA.	7.7 A	
Important: It any Injury o once.	21.	Signature of Funeral Service	Licensee	~/	METRO		Name end Add	4 50 1414	ORGE P			AL HOME	
any li		Male.	1.	6	5	29	73 SOLO	MONS ISLA					
	230	e. Pert1. Enter the disease, or shock, or heart failure. List	complication	s that ceuse	d the deeth. D						1	Approximata Intarval Batween	
sician											1	Onset and Deet	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decadent's Nama (First, Middla, Last) 3. Tima ol Death 2000 Month **Physician** July 30, 1:37 AM Lawrence Michael Tyson /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Ann
If Under 24 Hrs. | 8. Data of Birth
Hours | Min. | (Month, Day, Year) Arundel Center Anne Arundel Medical Anne If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 12 M 2□ F Director 1938 Wash. 230-50-5326 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yas 2 No Director Riva Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð Norms 23a Funeral 42 Shorewalk Road U.S.A. 14. Raca - American Indian. 21140 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status Black, Whita, atc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: White À 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygione. Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail Pages 1 and 2 should be filed vinent of Health and Mental Hygie ant; if Ibern 27 is marked other 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Elder A. Tyson Eloise K. Nyce 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other treu-2008. Eloise Tyson/mother 21140 42 Shorewalk Rd. Riva, MD 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata 1 ⊠Burial 2 □ Cremation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Fairfax Mem. Park 8/2/00 Fairfax, VA 22. Nama and Addrass of Facility 21. Signature of Funeral Survice License John M. Taylor Funeral Home 23a. Part1. Enlar the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Annapolis MD Approximate Interval Batwean Onset and Death Physician **IMedical** nonsmall all lung cancer 3 months Immediata Causa (Final diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): physician sthe burial 68760 Physician/Medicai Due to (or as a consequence of): Box 188 signed by the a 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O 1 Yes 2 No 3 Probably 4 Unknown م Records, þ 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was en autopsy performed? Completed page 2 s 1 Yas 21 No 1 Yas 2 TNo 25. Wes case refarred to medical Be 26. Place of Deeth (Check only one) Certification: To

Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director, it is the funeral director.

Hospital: 1 | Inpatient 2E ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signatura and titla of certifier

29c. License number

QYY85Y

29d. Daje signed (Month, Day, Year)

ed cause of deeth (Horn 23a) (Type, Priot).

EM), 8028 Rutchie Huy Pasadena MD 2/122 KARIN M. DODGE MD

State Registrar

31. Data liled (Month, Day, Year)
AUG 0 1 2000 32. Registrer's Signatura

AUG 0 1 2000 . We was a said

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth Month Carol J. Torello July 31 2000 3:20 pm 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Center Rising Sun If Under 24 Hrs. 8 Hours Min. Cecil If Under 1 Yeer 5. Sociei Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 X F Months Deys 376-32-2323 65 Dec. 8, 1934 Michigan Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No New York Erie Grand Island 10e. Street end Number 10f. Zip Code 10g Citizan of What Country? 1788 Bedell Road 14072 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 Nevar Married 2 Marriad 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Coliaga (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilbert Tomlinson Bertha McWha 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Sharon L. Wright 1788 Bedell Rd., Grand Island NY 14072 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeside Cemetery 8-4-00 Port Huron, Michigan Tulb of Funeral Service Licans 22. Name end Address of Fecility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 1. Entar the disease, or complete, or heart failure. List only or by the caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, Approximate Interval Between Onsat and Death Immediate Causa (Final disease or condition resulting in deeth) 12 Wes ada Part II. Other algnificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yas 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed?

Physician /Medical Examiner

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Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certific

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Records, P.O.

Division of Vital

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Director

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mod call Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23, any Injury or other traumatic event, the Medical Examinar mass.

Saltimore, Maryland 21215-0020

the Maryland

with

Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceusa (Diseese or injury that initiated events resulting in daath) Last

1 ☐ Yes 1 ☐ Yes 2 ☐ No 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case refarred to medical axaminar?
1 ☐ Yes 2 1 No 27. Manner of Deeth

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Panding investigation

28b. Time of

28c. injury at Work? 1 Yes 2 No

28d. Dascribe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Naturat

3 Suicide

2 Accident

4 Homicida

1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and plece, and due to the causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, deta end place, and dua to the ceuse(s) end manner stated.

29b. Signature end title of cartifier

29c. License number

29d. Date signed (Month, Day, Year) 31

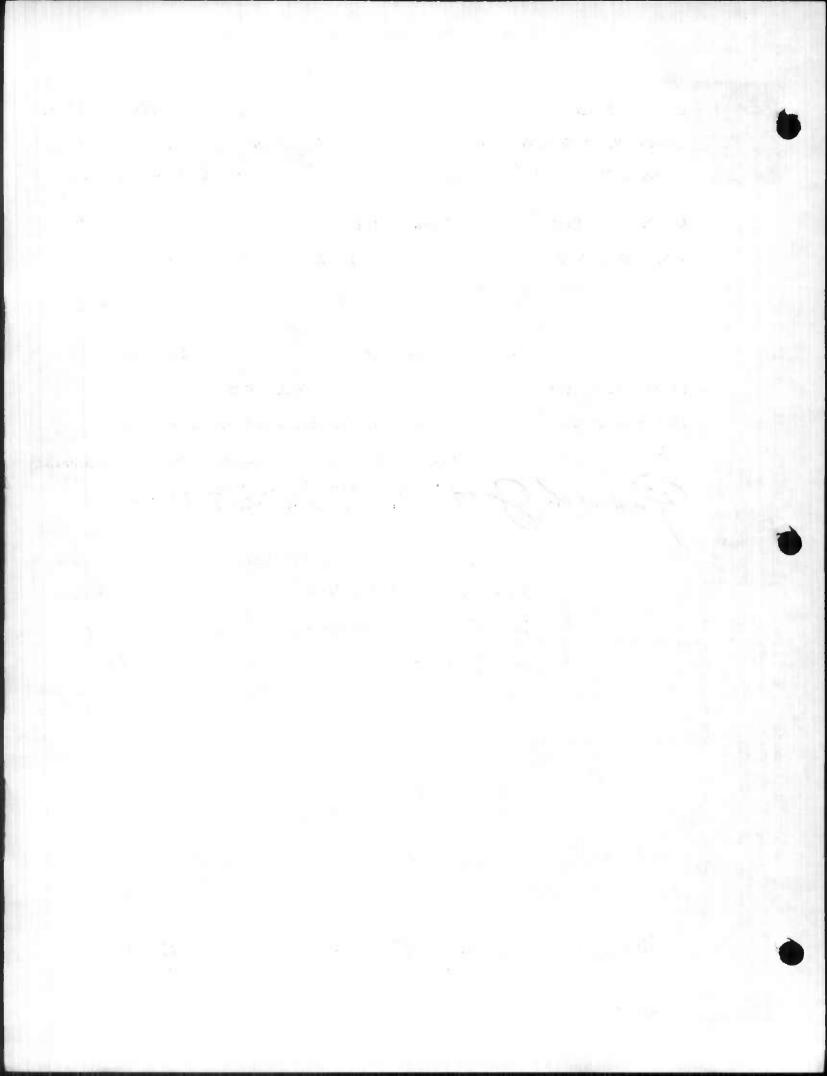
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30. Name end eddrass of person who complated cause of death (Itom 23a) (Type, Print)

Malcolm D. Phillips, MD Masonic Building Darlington, MD 21034 31. Date filed (Month, Day, Year) AUG 02 2000

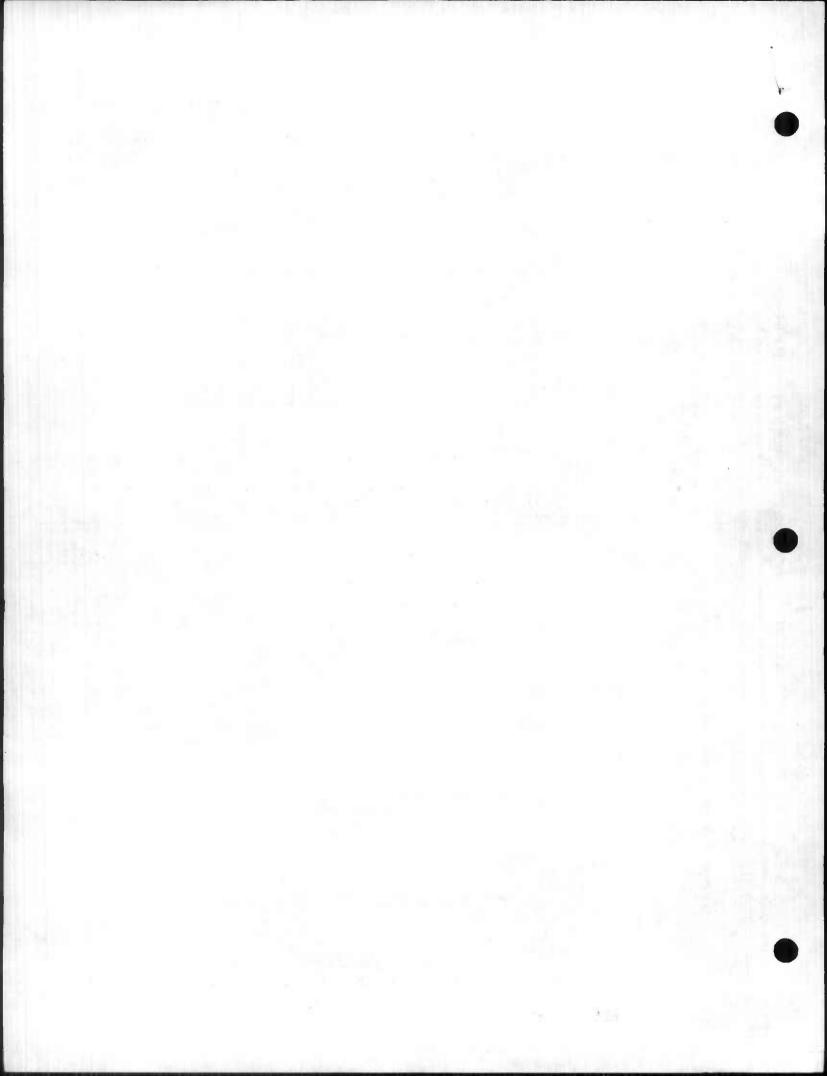
28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify)

State Registrar 32. Registrar's Signature



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nysician	Decedent's Name (First, Middle H.C.	ward Wil	liam I	harp					2. Date of De Month AUGU	Dey	1, 4	³ 2000	Tima of Death 1:20 AM
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	VA MARYLAND HE	ALTHCARE	SYSTE	EM			PERRY				CEC:	IL	
ral tor	5. Social Security Number 216-18-9474	6. Sex † <u>OX</u> M 2□ F		n yrs. last b	Yrs. If U	nder 1 Year hs Days		Min.	8. Date of Bi (Month, D. July 1	rth ay, Year) 6, 191	1	Birthplace Country) West	Virginia
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96	17. Father's Neme (First, Middla,	Last)					18. Mother	r's Name	(First, Middle	, Maiden Su	mama)		
0	A11e	n Tharp							Sabi	na Hol	mes		
	19a. Informent's Neme/Reletions			19	b. Mailing Add	ress (Street	and Number	r or Rura	I Routa Numb	ber, City or T	own, Sta	ata, Zip Co	de)
	Emma Jean Walke	r			18709 R		g Acre	s Wa	y, 01n	ey, Ma	ry1	and	20832
¥XXBuria 4 □ Done 21. Signature	20a. Method of Disposition	2		20b. Place camete	of Disposition ery, crematory	Nama of or other pla	ce)	1	Date	20c. Local	ion - Cit	ty or Town,	Stete
	4 Donetion 5 Other (5		III State		ingside			8	/3/00	Renic	k,	West	Virginia
	21. Signature of Funerel Service Licensee Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766												Α.
	23a. Part1. Enter the disease, or				not enter the	node of dyi	ng, such as o	cardiac o	r respiratory	errest,	0	Ap	proximete
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Finel disease or condition PNEUMONIA											UNKNOWN	
Jer	resulting in death)				consequence		EASE					UN	IKNOWN
Examiner	Sequentially list conditions	b			consequence							, Olifatoviti	
Ц	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that included security				FIBRILL							UN	IKNOWN
	Cause (Disease or Injury that initiated events resulting in death) Last	d			consequence								
Physician/Me	Part II. Other significant condition	ms contributing to	death but n	ot resulting	in the underlyi	ng cause gi	ven in Part I.		23b. Did	tobacco ua	a contri	Ibuta to the	e cause of death?
													ly 4½ Unknown
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									10	Yes 201	No	1 🗆 Ye	es 2 No
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	examiner?	Hospitet:] Inpatient	2 ER/0	Outpatient 3	DOA O	hor		ma 5□Res		Other	(Specify)	
	27. Manner of Deeth 1 Neturat 5 Pendir 2 Accident investi		te of Injury onth, Day Ye		Time of Injury	28c. Inju Wo		1	28d. Describe				
	3 Suicide 6 Could 4 Homicide determ	ined 286. Plac	ce of Injury Iding, etc. (S	At home, to Specify)	larm, street, fe	ctory, office		2	28f. Location City or To	(Street and I own, State)	lumber	or Rural Ro	outa Number,
edical Certification:		g Physician: To the Examiner: On the and ma		minetion a									
E	29b. Signeture end title of certifie	().				29c. Licens	se number			29d. Date s	igned (/	Month, Day	r, Year)
		Mel	0			D20	215			AUGUS!	r 1,	2000)
	30. Neme and address of person KARMACHANDRA NA							EM,	PERRY				902
tate	31. Dete filed (Month, Day, Year)		Registrar's	Signature	<i>b</i> .	Space							

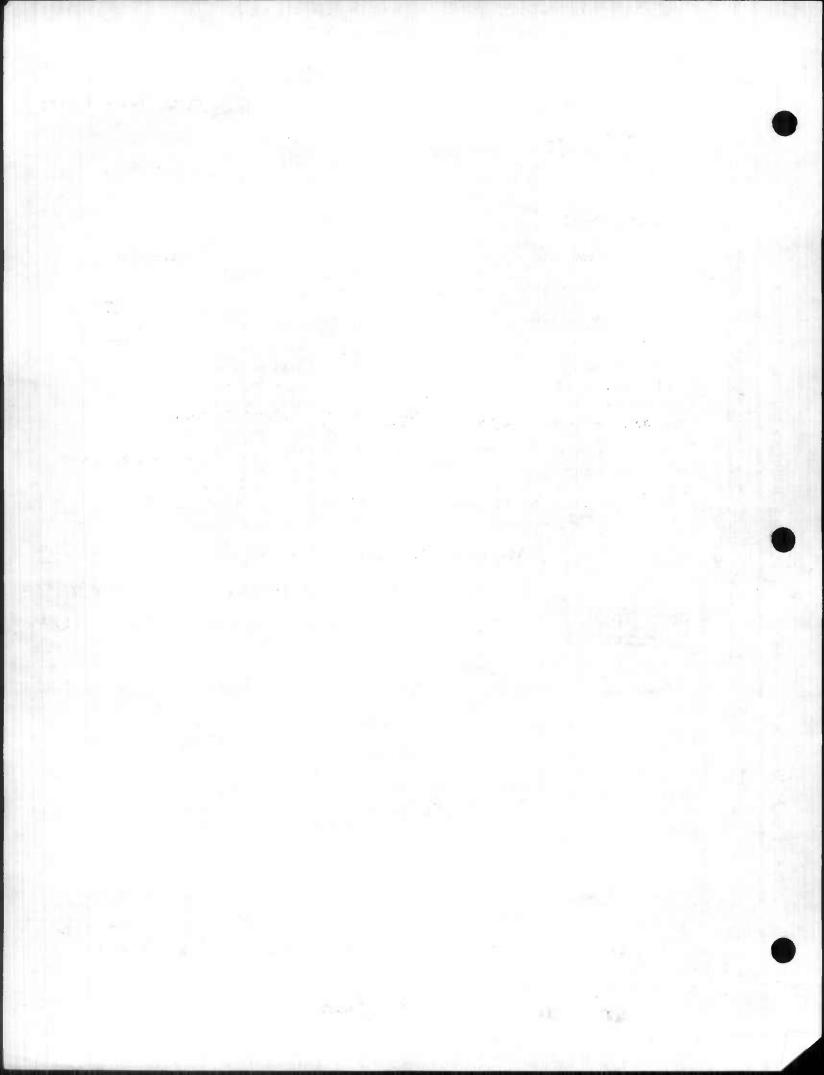


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 4b. City, Town, or Location of Death 1914 Warren H. Tiley 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Union Hospital El.kton 5. Social Security Number 6. Sex 1- M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 293-09-9522 Director NOV 18, 1918 Ohio Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits r 28a-f sh notified 1 Yes 2 No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a 55 Perch Creek Road 21921 Funeral United States 12. Was Decedent Ever in U.S.
Armed Forces? 194
1 2 Yes 2 No
If Yes, Give Year or Dates: 194 14. Race - American Indian, Black, White, etc. 'natural', or Items 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1941 72 hours after 1 □ Never Married 2 □ Married 21215-0020 to 1 ☐ Yes 2 No Specify: Specify: à 3 ☑ Widowed 4 ☐ Divorced White 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. Beverage Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer/ Salesman/Delivery Driver 10 Distributor Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tank of Its marked off lury or other traumatic aven Be Edwin Louis Tiley Signa Borjvig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Water Street, P.O. Box 143, Charlestown,
Maryland 21914-0143

20b. Place of Disposition (Name of cemetery, crematory or other place).
Immaculate Conception Irma Jeannie Chester/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/4/00 Elkton, Maryland Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 borned Sea 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final a. ACUTE MYOCANDIN INFANCTION

Due to (or as a consequence of): disease or condition resulting in death) Examiner Examiner COROWARD ARTERY MSEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ARTEMOSCIENOTIC CHEDIOURSCULAR MSENSE 10 YEARS physician at the burlel Box 68760. Physician/Medical for use signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1□ Yes 2☑ No 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) galustelle long 00007463 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rolando A. Najera, M.D., 111 W. High Street, Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature State books Depende AUG 0 4 2000 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July **Physician** Carolyn R. Tarr 31, 2000 3:15 AM /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 10M 20F 9, Maryland Director 220-30-2338 67 Usual Residence of Deceden 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits ahon must be notified at 1 Yes 2 No Directo 28a-1 Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? b hams 23a 21205 U. S. A. 531 N. Robinson Street Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 10 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, atc. 11. Marital Stalus Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: ģ 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygiers Important: if Nem 27 is marked other tha any injury or other traumatic other tha anse. 8th Grade Charwoman City Government 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Charles H. Thiess Emily Blanche Peterson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Milton A. Tarr (Son) 428 Waters Watch Court, Middle River, Md. 21220 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood 8/3/00 Baltimore, Maryland 22. Nama and Addrass of Facility Schimunek Funeral Home Inc. 21. Signature of Funaral Service Licensee mars 7 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Batween Onset and Daath Physician /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) 88 for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of causa of deeth? should 24a. Wes an autopsy performed? Completed page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital fospital or Attending Physician: TI 6 hours after death.

"uneral Director: After this certificate by filled in by the funeral director, ps 25. Was casa refarred to medical axaminer?

1 Yes 2 No Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Definer (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medicai 29e. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Dale signed (Month, Day, Year) 7/31/00 D43725 MD 21277 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Neck Rd Baltimore IARIO MAHMUUD

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG 3

2000

32 Hag strar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Lawrence C. Uptegrove **Physician** July 31 2000 7:00AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Malcolm Grow Medical Center AAFB Camp Springs Prince George's If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In y.s. last birthday) If Under 1 Year 5. Sociel Security Number Sex → M 2□F Birthplace (State or Foreign Country) **Funeral** Days 577-48-7714 Director New Jersey Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Forestville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Items 23a or 2810 East Avenue 20747 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Dates: 14. Race - American Indian. 11. Meritei Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 72 hours after Never Married 2 Merried Saltimore, Maryland 21215-0020 8 1 ☐ Yes 2 【XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Il Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A Kitchen Assistant Hospital 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental I 8 William D. Uptegrove Alberts R. Crisman 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Alberta C. Hitt (Mother) 2810 East Avenue Forestville, Maryland 20747 Department of Heelth Important: If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)

August 3 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State b Blairstown, New Jersey Cedar Ridge Cemetery 2000 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerat Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 Charles L. Belen 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical obstructive Pulmonan disese Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760. attending physician Due to (or es a consequence of): use 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown yd bengis py of Vital Records. 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en autopsy performed? Be Completed page 2 s After this certificate has 1 Yes 2 NA 1 ☐ Yes 2 X No Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No cours after death.

*al Director: After h.

* by the funeral dir Certification: To 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1. Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner stated. edical 29a. Certifier compietaly (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 126 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Surratts Rd \$1307. Clinton, mo 20735 A. Patelmo. Suresh 7501 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State AUG 0 2 2000

DHMH 16 Rev 6/95

Registrar

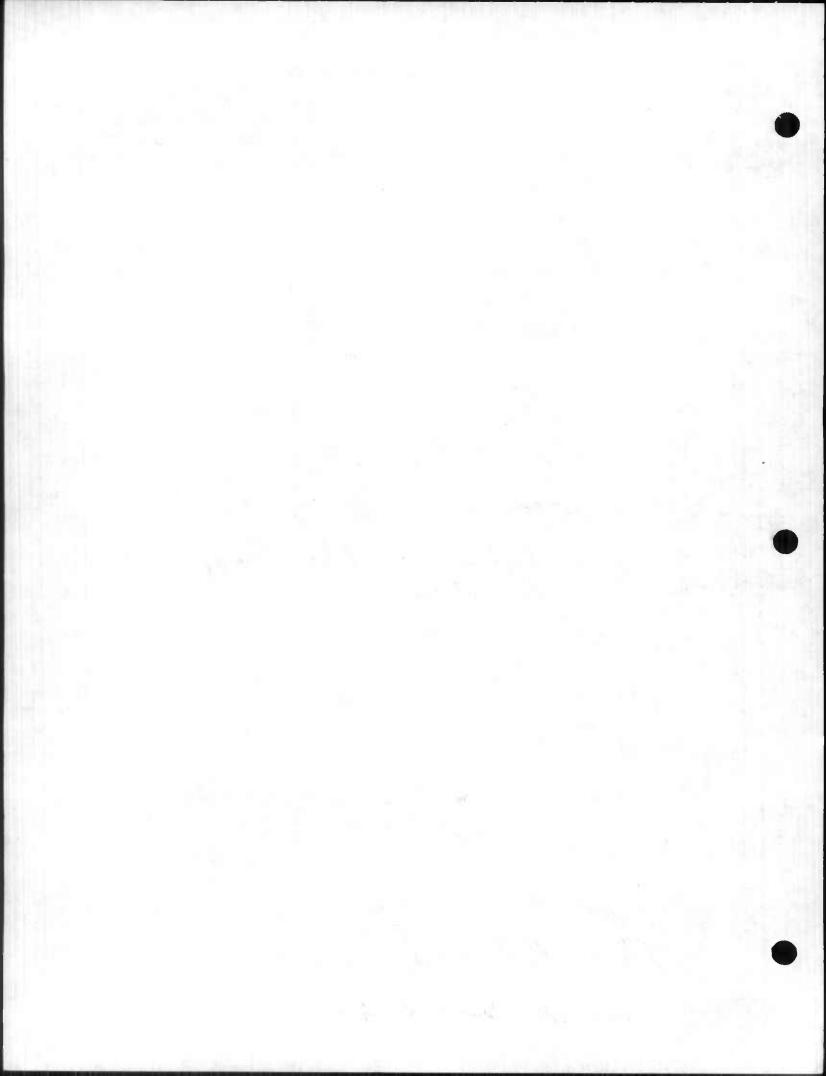
RICHARD VANGOSEN SR. JVW 00-4336-510

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 26 175

Certificate of Death

Physician	1. Decedent's Name (First, Middle, Last		Oertificate o	Dodin	2. Date of Deeth Month	Day Yeer	3. Time of Death			
/Medical			sen, Sr.	Ab City Town or I		ST 02, 200				
Examiner	4a Facility Name (If not institution, give 6820 GERMAN HILL			4b. City, Town, or L BALTIMO		4c. County of Dea	atri			
Funeral Director	5. Sociel Security Number 6. Se		yrs. If Under 1 Ye Months De		8. Date of Birth (Month, Day, Y June 11,	•	rthplace (State or Foreign country) St Virginia			
2	Usuel Residence of Decedent	10.04.7					Land of the			
Marylar and ahow	WV Morgan		wn or Location celey Spring	gs		10d. Inside City Limits				
with the 3a or 28	10e. Street end Number 906 Berry Street		10f. Zip Code 254	6 411	100	10g. Citizen of What Country? U.S.A.				
5-0020 72 hours after death with the Maryland natural; or items 23s or 28s4 show are I harriest must be notified at steel by Funeral Director	11. Maritel Status 1 Never Married 2 N Nerried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U.S. Armed Forces? VIXYes 2□No War If Yes, Give Year or Detes: Korean	13. Wes Decedent of If Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Reca - Am Bleck, Wh Specify: V				
72 hours natural; deal East	15. Decedent's Edu (Specify only highest grad		a. Decedent's Usual Oct (Give kind of work do life. DO NOT use ret	cupetion ne during most of work	king	6b. Kind of Business	s/Industry			
d withing giona.	Elementery/Secondery (0-12)	College (1-4or 5+)	Landscape:			Lands	scaping			
Maryland 2 d 2 should be filled th and Mental Hygis 7 la marked other traumatic event, II TO Be Cc	17. Fether's Name (First, Middle, Last) Berkeley Ci	arter VanGo	sen	18. Mother's Nem Martha	ne (First, Middle, Ma Elle		arney			
CENL	19e. Informent's Neme/Relationship (7) Richard D. VanGose		b. Meiling Address (Stre 31 Glenwood							
Dallimore, emit. Pages 1 an emit. Pages 1 an emit. Mesi mortant: If Nem2 in Injury or other	20e. Method of Disposition 1 🖾 Aurial 2 Cremation 3 🗆 F 4 🗎 Donetion 5 🗎 Other (Specify)	remove from State	of Disposition (Name of ery, crematory or other p way Cemeter	- 1		erkeley S	Town, State			
Demit. Departm Importer any injur	21. Signeture of Fumeral Service Licensee M00522 M00									
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Heupestoner	a consequenca of):	poter a	energy.	will				
certificate be executed inding physician end use es the buriel-transit in Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a	consequenca of):							
et the death d by the attendance of the control of	Part II. Other eignificant conditions con	ndiffere contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.								
The lew requires the last been signed page 2 should be d						le. Wes an eutopsy performed? 24b. Were autopay evailable proposition completion				
VICAL THE IEW Certificate has b rector, page 2 s					10 Yes	2 No	of death?			
Be (Be (25. Wes case referred to medical examiner?				th (Check only one	2				
Property of the property of th	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospitel: 1 Inpatient 2 ER/C 28a. Dete of Injury (Month, Day Year)	Other: 4 Nursing H	ome 5 Residen 28d. Describe how		pecify) SCENE				
Hospital or Attending P 44 hours after death. Funeral Director: After they filled in by the funeral lical Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Stre City or Town,		Rural Route Number,				
Hospita 4 hours Funeral tely fille										
To the comple	29b. Signeture and title of certifier	U. Kerk		ense number C.M.E.	29	d. Date signed (Moi AUGUST 0				
	30. Name and address of person who or	ompleted cause of death (Item 23a) (Type, Print)	Street, Bal	Itimore 1	Marvland	21201			
State	31. Date filed (Month, Day, Year) ALIG 0 4 200	32 sistrer's Signature		Ks/	LUMINIC, I	ALLY MIKE	L.L. L.			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 1, 2000 Peggy J. Williams 11:23 AM /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Takona Park Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth AMonth Day/Year 048 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 10 M 200 North Carolina 216-74-9964 51 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Bladensburg Maryland Prince George's Director Name 23s or 28s-f the Medical Examiner must be notifi-10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20710 U.S.A. 3801 Kenilworth Avenue Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Merital Status 1 Never Merried 2 Merried 1 ☐ Yes 2 XNo If Yes, Give 8 Saltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specity: Black Ag 3 Widowed 4 □ Divorced Year or Detes Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 10th grade Unemployed N/A 18. Mother's Neme (First, Middle, Meiden Surname) 17. Fathar's Neme (First, Middle, Last) should be Mental Uhknown Finice Campbell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Mrs. Margylene Haley (Sister) nt of Health to if them 27 h 3801 Kenilworth Avenue Bladensburg, Maryland 20710 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/4/2000 Chesapeake Crematory, Inc. Beltsville, Maryland 22. Name and Address of Facility HOVE, INC. 21. Signature Funerel Service Libenses 4339 HINT PLACE, N.E. WASHINGTON, D.C. Approximate Interval Between Onset end Deeth the disease, or complications that caused the definer failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory errest, 23s P **Physician** Immediete Cause (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner TUMMU i or Attending Physician: The law requires that the death certificate be associated after death.

Director: Atten this certificate has been signed by the attending physician and cin by the inverted inector, page 2 should be deteched for use as the bunal-transit of in by the inverted inector, page 2 should be deteched for use as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Box 68760, Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ponknown λq Division of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical axeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital e within 24 hours a To the Funeral D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and #file of/certific 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) NWADIUKO, MD MOND 20106 31. Date filled (Month, Day, Year) 32. Registrer's Signeture State AUG 0 4 2000

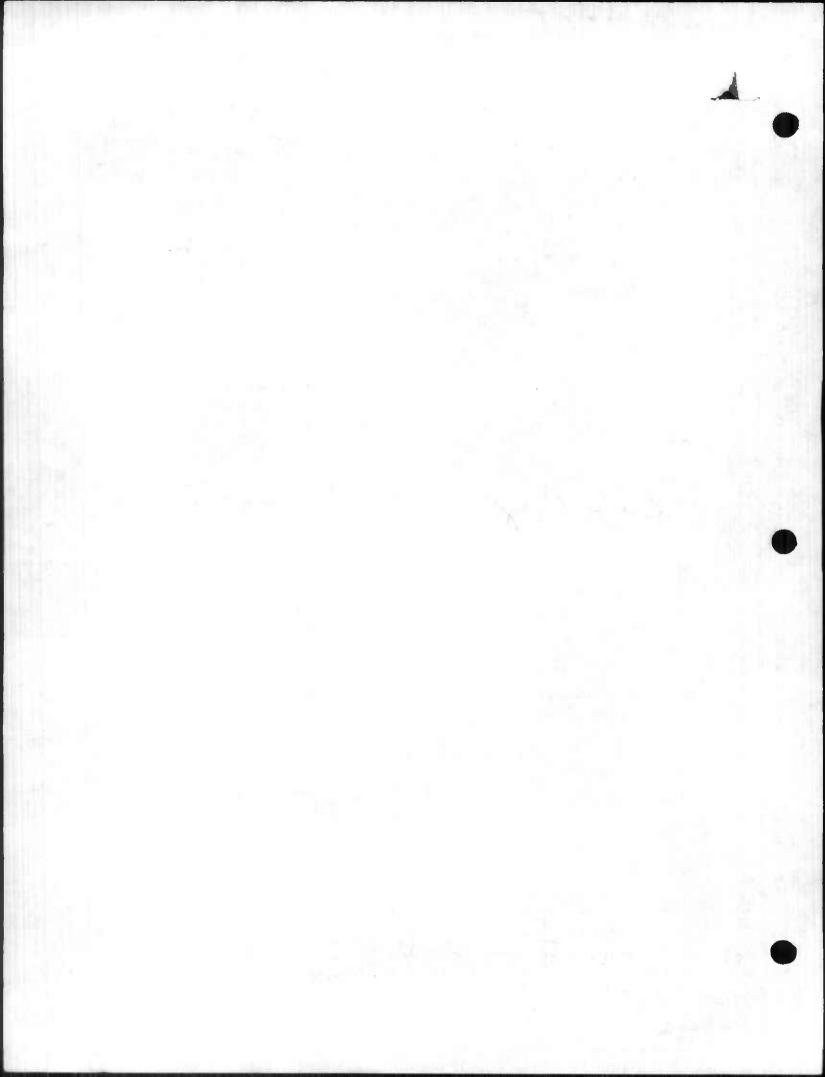
DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 10 26170

nysician	1. Decedent'a Nama (First, Middle, Last)			2. Date of Dear	th	3. Tims of Death
in al	Kirk	Williams			AUGUST		
er	4a Facility Name (If not institution, give			lb. City, Town, or L	ocation of Death	4c. County of	Death
	MARYLAND CORRECT			JESSUP			ARUNDEL
	5. Social Security Number 6. Sa 577-74-3774 Usual Residence of Decedent	7. Age (In yrs. last	birthday) If Under 1 Yaar Months Days	Hunder 24 Hrs. Hours Min.	8. Data of Birth (Month, Day 6-4-195	Yaar) Wa	9. Birthplace (Stata or Foreign Country) ash., D.C.
	10a. State 10b. County	10c. City, To	own or Location			4.5	10d. Inside City Limits
Funeral Director		Wash	ington,D.C.				1X Yas 2 No
100	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	608 Emmanuel Court	, N.W. #201	20001			USA	
	11. Marital Status 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedant of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ecify Yas or No- Rican, etc.)		American Indian, White, etc.
	15. Decedent's Edu		6a. Decedent's Usual Occupa	ation		16b. Kind of Busi	
Completed	(Specify only highest grad Elamentary/Secondary (0-12)	(e completed) Collega (1-4or 5+)	6a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	during most of world)	ring		
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	17. Father's Nama (First, Middla, Last)			18. Mother's Nam		Maiden Sumame)	
1	James Edward Willia		04-14-11-1				tota Tio Codel
	19a. Informant's Name/Relationship (T)		9b. Mailing Address (Street a				
1	Veronica L. Willia 20a. Method of Disposition	20b. Place	3805 Endicott of Disposition (Name of			Le,Md. 20 20c. Location - C	U / /4 ity or Town, State
	1 ☐ Burlal 2 ☐ Cramation 3 ☐ 8 4 ☐ Donation 5 ☐ Other (Specify,	demoval from Stata	otery, crematory or other placest Hills Cemet		/12/00	Clinton.	Maryland
1	21. Signature of Formula Sarvica Licens		22 Name and Address				
	1/10 /	7 /	389 R.I.				01
1	23a. Partt. Enter the disease, or comp shock, or heart failura. List only o	lications Val caused the death. D		_		-	Approximate
	Immediate Cause (Final disease or condition	NARCOTIC I	NTOXICATION EROTIC CAR	N IN AS	SOCIATI	ON WITH	Intarval Between Onsat and Death
	rasulting in death)	Due to (or as	a consequenca of):				
Aedical Examiner		b. —————					
	Sequentially list conditions, if any, leading to immediate	Dua to (or as	a consequance of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events	c					
edic	resulting In death) Last	Due to (or as	a consaquence of):				
	Mary Comment	d					
riiyaiciaitu	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause give	en in Part I.	23b. Did to	obacco use cont	ributs to the cause of death?
	DIABETES MEL					'88 2 No :	
2	PERIODING MEDI						
palaidilloo					24a. Was a perform		24b. Wera autopsy findings svailable prior to completion of cause
						/	of death?
					DY	es 2 No	1 Pas 2 No
1	25. Was case referred to medical examiner?	Hospital:	Coh	1111	th (Check only or		
-	1 XYes 2 No 27. Manner of Death	1 Inpatient 2 I ER	Outpatient 3 DOA Other	4 U Nursing H		ence 8 Other	(Specify) SCENE
Certification	1 Natural 5 Pending investigation	Found: 00 F	SUND:W 10	yat k? Yas 2 DKNo	UNK	NOWN	
	3 Suicide 64 Could not be detarmined	28a. Place of Injury - At homa building, etc. (Specify)					RYLAND CORREC
	20a Cartifier	FOUND IN J		no data and state		INSTI	
edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my knowled ner: On the basis of examination and mannar stated.	age, death occurred at the time and/or investigation, in my of	ne, date and placa, pinlon, death occur	red at the time, d	ausa(s) and man lata and pisca, sr	nar as stated. MD.
	29b. Signature and title of certifier	A 0	29c. License	e number	2	29d. Date signed	(Month, Day, Year)
	1 (1- Put	ane M	D OCM	E		AUGUST	04, 2000
-	30. Name and addrass of person who ca	omplejed cause of death (Itam 23	a) (Type Print)				
	30. Name and address of person who co	restaner	III Penn Stre	et, Balt	imore, M	aryland	21201

DHMH 16 Rev 6/95



	State of Maryland / Department of Health and N Certificate of Death		ene () ()	26177						
	Decedent's Nama (First, Middle, Last)	2. Data of Death Month		3. Time of Death						
Physician /Medical	LETTIE M. WHEELER	July	26 2000	11:00 a.m.						
Examiner	4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Li	ocation of Death	4c. County of Deeth							
	SOUTHERN MARYLAND HOSPITAL CLINTON		PRINCE GEO							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 1 Under 1 Year 1 Under 24 Hrs. 4 Months 7 Pyrs. 1 Under 24 Hrs. 4 Months 7 Pyrs. 1 Under 24 Hrs. 7 Pyrs. 1 Under 24 Hrs. 8 Months 9 Pyrs. 1 Under 24 Hrs. 9 Pyrs. 1 Under 24 Hrs. 2 Under 24 H	8. Dete of Birth (Month, Dey,		nplace (Stete or Foreign untry)						
Director	228 30 7342 1 M 2 N Yrs. Wrs. Wrs. Wrs. Wrs. Wrs. Wrs. Wrs. W	Septembe	er21,1912Vi	rginia						
P 8 m	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
Mary Mary Hotel	Maryland Prince George's Clinton			1 ¥ Yes 2 □ No						
or 28e-fr or 28e-fr as notifie Directo	10e. Street and Number 10f. Zip Code	10	g. Citizen of Whet Co	untry?						
4 2 4 4	8901 Shannan Drive 20735		USA							
her death there is siner mu	11. Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puarto	ecify Yes or No- Rican, etc.)	14. Rece - Amer Bleck, White							
D20	1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No H Yas, Give 1 ☐ Yas 2 ☑ No Specify:		Specity: Bla	ck						
21215-0020 at within 72 hours at gene. Then metural, or then medical Exam Completed by F	15 Decedent's Education 15e Decedent's Liquid Occupation	1	6b. Kind of Business/I	ndustry						
215 In 72 In	(Specify only highest grade completed) (Give kind of work done during most of work	ing								
1 2121 act within tygione, wer than At, the Me	Elementary/Secondary (0-12) College (1-4or 5+) 11th Housewife		Private							
and the second	17. Fatner's Name (First, Middle, Last)	e (First, Middle, M	teiden Surname)							
yla Ment Ment Ment Ment Mic e	Charlie Clark Fannie	Jones								
Maryland 2 should be fine th and Mental Hy 7 is marked other treamedic event	19a. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rut		-	ip Code)						
- 로듬하노	Bobby Austin /nephew 8901 Shannan Drive Cli 20a. Method of Disposition 20b. Place of Disposition (Neme of			Town State						
Total and a state of the state	tsBeurial 2 □ Cremation 3 □ Removal from Stata cemetery, cremetory or other piece)		20c. Location - City or							
Him Pa	4 □ Donation 5 □ Other (Specify) Hickman Family Cemetery 7									
Baltimore, permit, Pages 1s permit. Pages 1s permit of his important if her any highry or othe pose.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746									
STATE OF THE PERSON NAMED IN	23a. Part1. Enter the disease, or complications that caused the daath. Do not enter tha mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiretory arre	st,	Approximate Interval Between						
Physician				Onset and Death						
/Medical Examiner	immediate Cause (Final disease or condition resulting in death)			I week						
5	Due to (or as a consequence of):			7 lns						
owecuted n and lateransit	b. Dementia			20						
executial-trainel-trai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			/ Man la						
68760, ifficate be executed g physician and as the burial-transit ledical Examir	Thet initiated events			Gilone						
S the state of the	resulting in death) Last		- 20- 20							
P.O. Box 68 Let the death certificate by the attending phetached for use as the physician/Med Physician/Med	d.									
the dear y the a sched f	Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I.	23b. Did tol	bacco uas contributs	to the cause of death?						
S, P.O. B as that the death gened by the atter be detached for by Physicia		1 🗆 Ye	a 200 No 3 Pr	obably 4 Unknown						
		24e. Wes er	eutopsy 24b. V	Were autopsy findings						
0 > 0 =		perform	ned?	evailable prior to completion of cause of death?						
ii Record The law require tale has been si- page 2 should I		1 □ Ye		I ☐ Yes 2 ☐ No						
= F # a O	25. Was case referred to medical 26. Place of Dee	th (Check only one		10165 2010						
	examiner? Hospital: Other:		nce 6 Other (Spec	cify)						
0 5 5 8	27. Manner of Death 28a. Deta of Injury 28b. Time of 28c. Injury at	28d. Describe ho								
VISION Attending or death. ector: After by the fune iffication	2 Accident invastigation M 1 Yes 2 No									
Division of standing P is after death. In Director: After led in by the funeric Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Ru , Stete)	iral Route Number,						
Cel lod in Cel										
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occur and mannar statad.	end dua to tha ca red at the time, de	usa(s) and manner as ete end place, and due	to the cause(s)						
To the comp	29b. Signatura and title) of certifier 29c. License number	25	d. Dete signed (Mont)							
	12 DAD Allending D-245	35	07.20	5.00						
4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	L. Berwa, MD 7503 Surratts Rd Clinton, MD 20735									
State Registrar	AUG 0 1 2000 32. Register's Signeture 3.									

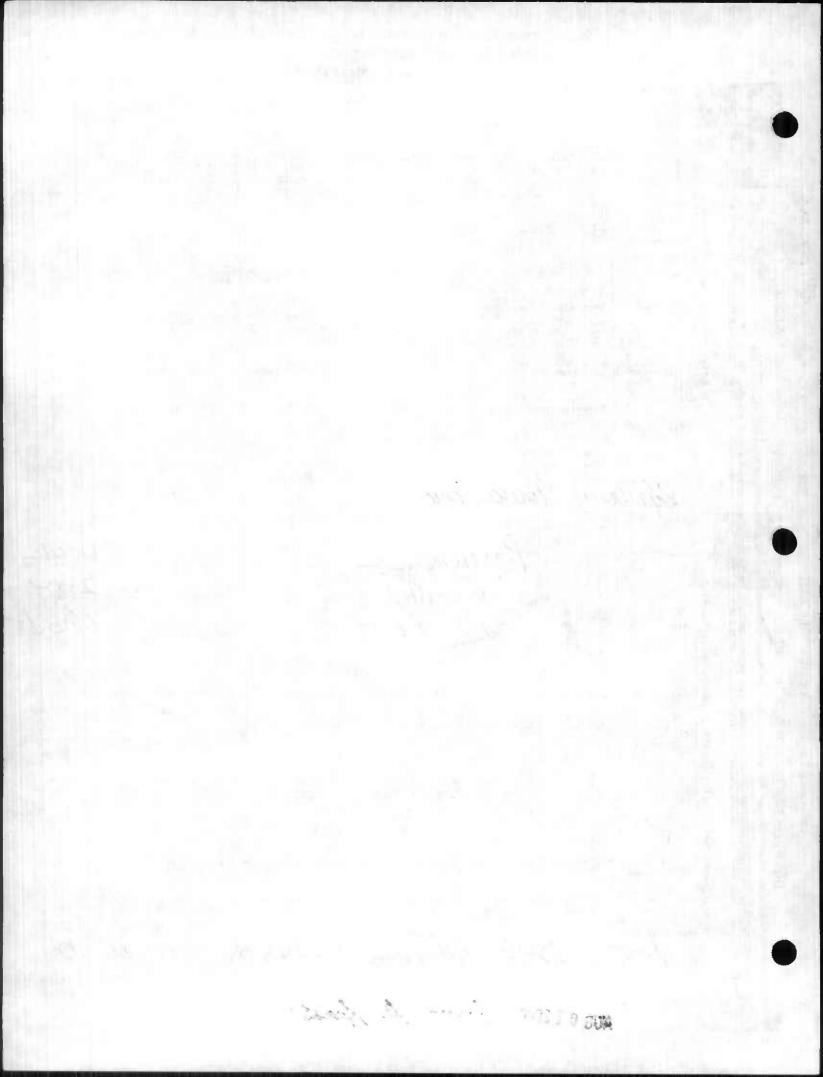
DHMH 16 Rev 6/95

ATN: Berwa

JR. Kalso

7/26/00

Wheeler, Lettie



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Whit marge 2000 /Medical 4a Facility Name (I not institution, give street end number) 4b. City, Town, or Location of Beath 4c. County of Death Examiner Gealth Frenghern MD. If Under 1 Year Clinton Mariner 0 Birthplace (State or Foreign Country) Age (In yrs. lest birthday) If Under 24 Hrs. **Funeral** Months Days Hours 578-48-6824 10 M 20 F 62 01 - 10 - 38Wash., Director Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at D. Washington X□ Yes 2□ No C Director 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? 20020 2315 Altamont Place, S. E. Apt. 1 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Merried Specify: Black Army 1 ☐ Yes 2 ☐ No Specify: by 3 □ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if frem 27 is marked other than any injury or other traumatic event, the seasons. Elementery/Secondery (0-12) College (1-4or 5+) U. S. Govt Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Jackson Inez Lewis 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2315 Altamont Place S Washington, D. C 20020 20b. Place of Disposition (Name of cametery, cremetory or other place) Date Calvin Young (Brother-in-law 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Quantico NationalCemetery 8-4-00 Triangle, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D. C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Unlanous Examiner to (or as a consequence of): Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician Physician/Medicai eun Due to (or as a consequence of) attending s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? the bed signed by the 3 Probably 4 Ponknown 1 Yes 2 No p 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ M 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier

Division of Vital Records.

that the death certificate be assecuted

The law requires

Box 68760.

P.O.

with the Meryland

72 hours after

Baltimore, Maryland 21215-0020

To the Hospital or within 24 hours aft To the Funeral Di-completely filled in

30. Neme and address of parts Arastoo Yazdani, M. D.

AUG O

31. Date filed (Month, Dey, Yes

tine of certi

1 2000

29b. Signature g

who completed cause of death (Item 23e) (Type, Print) ani, M. D. 9801 Ga. Ave., Silver Spring, Md. 20902 32 Registrar's Signature

MI

aminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2000

29c. License number

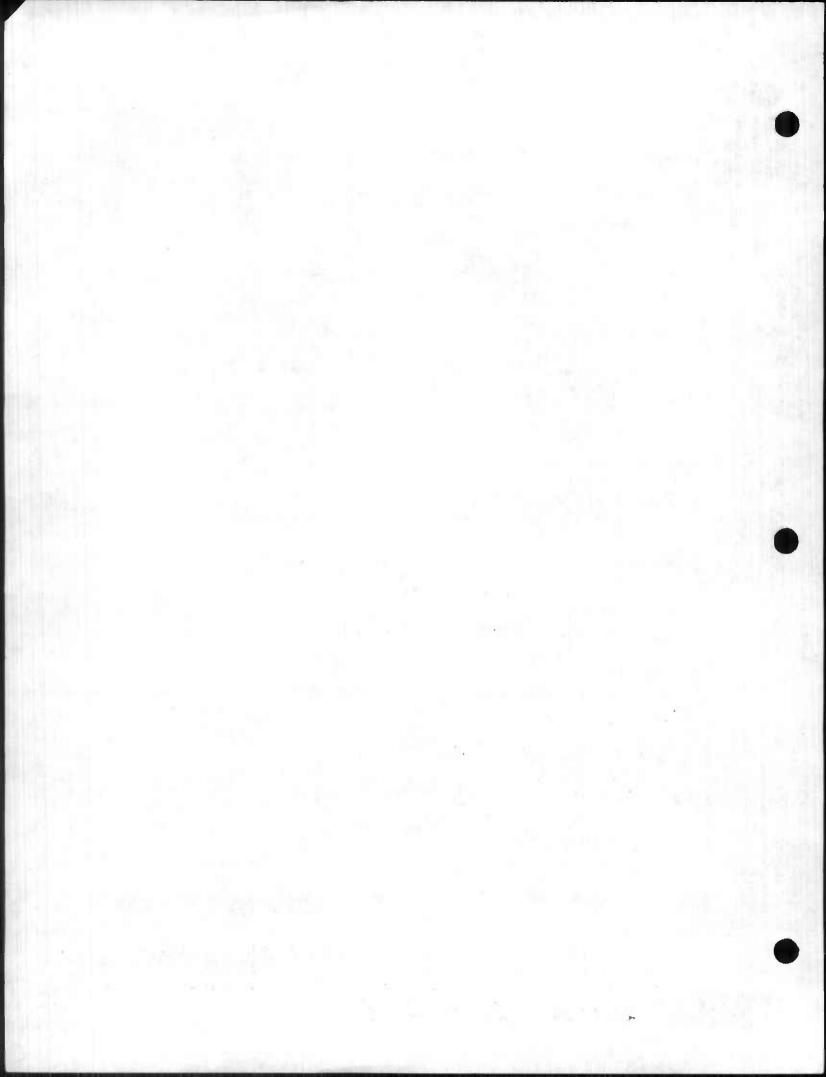
Registrar **DHMH 16 Rev 6/95**

State

State of Maryland / Department of Health and Mental Hygiene

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10	00	6	U	1	V	U

		Certificate of Death Reg. No.						
	THE LIGHT	1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth 3. Time of Death						
	Physician	Emma Jean Wheeler		August 3 2001	- 1			
	. /Medica Examine	4a Facility Name (If not institution, giva street and number)	4b. City, Town, or Lo					
	Examino	Washington County Hospital	Hagersto	own Washing	ton			
1	Funeral	5. Social Security Number 6. Sax 7. Age (In yrs. last birthday		B. Date of Birth 9. Bi	irthplace (State or Foreign			
	Director	435 74 8489 1 M 201 52 Yrs.	November 13, 1947 Mi	1947 Mississippi				
	D.	Usual Residence of Decedent						
	ahow	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits						
the Meryland 288-f show	Maryland Washington Clear S		1 ☐ Yes 2 🖾 No					
or 28		10e. Street and Number		10g. Citizen of Whet Country?				
firer death with the Me ritems 23s or 28s-1 a firer must be inclined.	1338 Blair's Valley Road	USA						
	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexicen, Puarto	pecify Yaa or No- Pican, atc.) 14. Race - Am Black, Whi					
20	or h	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ② No If Yes, Give	1 Yes 2 XNo Specify:	Specify: TT	Specify: White			
21215-0020	n 72 hours a natural", o	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						
5	led within 72 ho lygiena. ner than "naturi	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT usa retired)	ing	16b. Kind of Businass/Industry			
12	withir than	Elementary/Secondary (0-12) College (1-4or 5+)	emaker	Home				
	17. Falhar'a Name (First, Middle, Last)		e (First, Middle, Maiden Sumeme)					
Maryland	A Se De							
2	2 should be and Mentel in marked of eumatic even	Herman Lloyd Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rus	Maylee Matthews aral Route Number, City or Town, Stete, Zip Code) 21722				
Z	D 5 1 5		Blair's Valley					
é	of Heelth item 27 i	20a Method of Disposition 20b. Place of Disp	position (Nama of	Data 20c. Location - City o				
altimore,	00-	1 M Burlai 2 Cremation 3 Hemoval from State	ematory or other place)	10100				
量	it. P		ry Cemetery 8 22. Name and Address of Facility	/8/00 Shrevepor	t, La.			
Ba	Department Department Important: I any injury o		Gerald N. Minnio	ch 305 N. Pot	omac St.			
		Succes ()////well	Funeral Home	Hagerstown	, Maryland			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	tier the mode of dying, such as cardiac	or raspiratory arrest,	Interval Between Onset and Death			
	Physician / /Medical	Immediate Ceuse (Final	Λ • /					
	Examiner	disease or condition a. Cerebra Vascu	lar Accident		1			
		Due to (or as a conse	equence of):					
	e executed ien and unal-transit	Sequentially list conditions b. Diabetic Ret Dua to (or as a conse	oacidosis					
_6								
260	8 3 5 Cause (Disease or injury Cardial Intarction							
68	g phy as the	resulting in death) Last	quance or):					
X	inding use as	d						
Box	Seath ce attandii	Part II. Other significant conditions contributing to death but not resulting in the	23b. Did tobacco use contributs to the cause of death?					
0	by the lacked	A 1. Of	1 No 3 Probably 4 Unknown					
σ.	igned by De delt	Carotia Stenosis						
rds	The law requires that the death ce ate has been signed by the attending page 2 should be detached for us.		24e. Was en autopsy 24b	. Were autopsy findings				
00	s been s	Diabetes Mellitus	performed?	available prior to completion of causa of death?				
Re	The law ate has b page 2 s	1/1/20-11:10	1□ Yes 2ŪNo	1 ☐ Yes 2 ☐ No				
a	certificate rector, page							
5	s certification director	examiner? Hospital:	Other		200%()			
Division of Vital Records,	2 2 2	27. Manner of Death 28a. Date of Injury 28b. Time	Tag impatient 2 2 27/Odipatient 3 2 DOX 4 2 Notice 5 2 Nesidence 6 2 Other (Specify)					
On	ding in After After funer	1 Neturel 5 Pending (Month, Day Year) Injury 2 Accident investigation						
2	Attendil death. ctor: A y the fu	3 Suicida 6 Could not be 28e. Place of Injury - At home, farm, s	99 On Plant Line Allers for short less than 1991 Location (Street and Alumber or Plant Pouts Alumber					
Ö	aftar Dire	4 Homicide building, etc. (Specify)						
	No Hospital or Attending P n 24 hours after death. Se Funeral Director: After t pietely filled in by the funeral	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	- Ho 24 h Erur ietely	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.						
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
	. , , , ,	Jahren James Lung	1 52 0110	August 3 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
		Dr. Mc Gee 324 F. Ant	ietan St 11	46. MJ. 21711	0			
	State	31. Dele filed (Month, Day, Year) 32. Registrar's Signature		1, 100.0119	U			
	Registrar	AUG 0 4 2000 Beneva	sparks					



	Michael	C.	Wangerow
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State of Maryland / Department of Health and Mental Hygiene

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ician	Decedent'a Name (First, Middle, La		2. Date of Death Month Day Year							
dical	Michael C	W		August		000 04:50 A.M.				
niner	4a Facility Name (If not institution, give			City, Town, or Location of Death						
	Harford Me 5. Social Security Number 6.5		er 1 Year If Under 24 Hrs	de Grace 8. Date of Birth	rford					
or		M 2□ F	Yrs. Month				9. Birthplace (State or Foreign Country) MARYIANC			
	10a. Stata 10b. County	10c. (City, Town or Location	,			10d. Inside City Limits			
Director	md. Cec	il F	ORT DO	eposit		On Citizen of Mile	1) Yes 2□ No			
ral Dir	10e. Street and Number 1300 Susquehanna River 21904 10g. Citizen of What Country USA									
Funeral	11. Manital Stetus	12. Wes Decedent Ever in Armed Forces?	U,S. 13. Was Dec	edant of Hispanic Origin? (ecify Cuban, Mexicen, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Biack,	- American Indian, , White, etc.			
by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yea, Give Year or Detes:	1 ☐ Yes	No Specify:		Specify:	white			
Completed	15. Decedent's E (Specify only highest gra		16a. Decedant's Us (Give kind of v	vork done during most of wi	orking	16b. Kind of Busi	inass/Industry			
Idm	Elementary/Secondary (0-12)	Cottega (1-4or 5+)	`life. DO NOT	use retired)		1/1				
00	17. Father's Name (First, Middle, Last) _	/V PT	18. Mother's Na	ama (First, Middle,	Meiden Sumame,)			
To Be	RANDAI L	BRAGG		40	PORIC	4 0	gerow			
-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addra	ss (Street and Number or F		r, City or Town, S	itete. Zip Code)			
	Lu Ann Cusic	Social	170 E.	main St.	EIKT	on me	d. 21921			
	20a. Method of Disposition		. Place of Disposition (N	leme of rother plece)	Date	20c. Location - C	City or Town, State			
	1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specific		A. Ferris	eCo.	8/7/00	west (Chester, PA.			
	21. Signature of Fundral Service Lice	900 10	22. Name	and Address of Facility	ess of Facility , 259 E. MAIN St.					
	V Edwal M.	Acken	GOP	FILLEDA	Home EIKton, Md. 21921					
	23a. Part 1. Enter the disaas or com shock, or heart failure.	olications that caused the de	eath. Do not antar the m	ode of dying, such as cardin	ac or respiratory an		Approximata Intervat Betwaen			
n		3110 04000 011 44011 1110.					Onset and Deeth			
al er	Immediate Cause (Final disease or condition	SUDDEN U	JNEXPECTED	DEATH IN	INFANCY					
	rasulting in death)	Due to	(or as a consequence o	f):						
nine		b	b							
i Examiner	Sequentially list conditions,	Due to								
463	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying		C Due to (or es e consequence of):							
000	rany, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to	(or es e consequence of	I):						
Medicai	that initiated events		(or es e consequence of	1):						
	that initiated events	cDue to	(or es e consequence of	():						
	that initiated events	d					iributs to the causs of death?			
	Cause (Disease or Injury that initiated events resulting in death) Last	d					iributs to the causs of death?			
	Cause (Disease or Injury that initiated events resulting in death) Last	d			1 🗆 1	/es 2□ No :	3 Probably 4 Unknown 24b. Were autopsy findings			
	Cause (Disease or Injury that initiated events resulting in death) Last	d			101	/es 2□ No :	3 ☐ Probably 4 ☐ Unknown			
	Cause (Disease or Injury that initiated events resulting in death) Last	d			1 🗆 1	res 2 No :	3 Probably 4 Unknown 24b. Were autopsy findings available prior to compilation of cause of death?			
	Cause (Disease or Injury that initiated events resulting in death) Last Part It. Other significant conditions of the co	d		cause given in Parl f.	1 🗆 1	res 2 □ No :	Probably 4 Junknown 24b. Were autopsy findings available prior to compilation of cause			
	Cause (Disease or Injury that initiated events resulting in death) Last Part It. Other significant conditions of	d		cause given in Part f. 26. Place of D	24a. Was perfor	res 2 □ No san autopsy med?	3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
To Be Completed by Physician/M	Cause (Disease or Injury that initiated events resulting in death) Last Part It. Other significant conditions of the c	d	esulting in the underlying	26. Place of Do	24a. Was a perior 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	an autopsy med? Yes 2 No	3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Dete of Death **Physician** Michael David ZEIGLER 8: 10 AM 2000 03 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months 1⊠M 2□ F Deys 47 Yrs. 217-58-3979 Director May Maryland Usual Residence of Decedent y 28e-f show a notified at 10s State 10h County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yas 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 1401 Wellington Road Berne 23a 21740 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 1 ☐ Never Married 2 ☑ Merried "natural", or Maryland 21215-0020 1 Yes 2 No Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 truck driver trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Jonas W. Zeigler Marie V. Poffenberger 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa A. E. Zeigler - wife or other tr 1401 Wellington Road, Hagerstown, Md. 21740 Baitimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Pages nant of h 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important If eny Injury or page Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8-5-00 Hagerstown, Maryland 21. Signature of Fungral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each lina. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) bone Chicinema of Examiner Examiner Man physician and the buriel-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760, Physician/Medical Due to (or es a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown eniunul Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? pege 2 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1□ Yes 2 No Hospital: 1 Tinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To After this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation deeth. 2 Accident 1 Yes 2 No e Hospital or Attand n 24 hours after deeth te Funeral Director: / 3 Suicide 6 Could not be within 24 hours after de To the Funeral Directo complately filled in by th 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

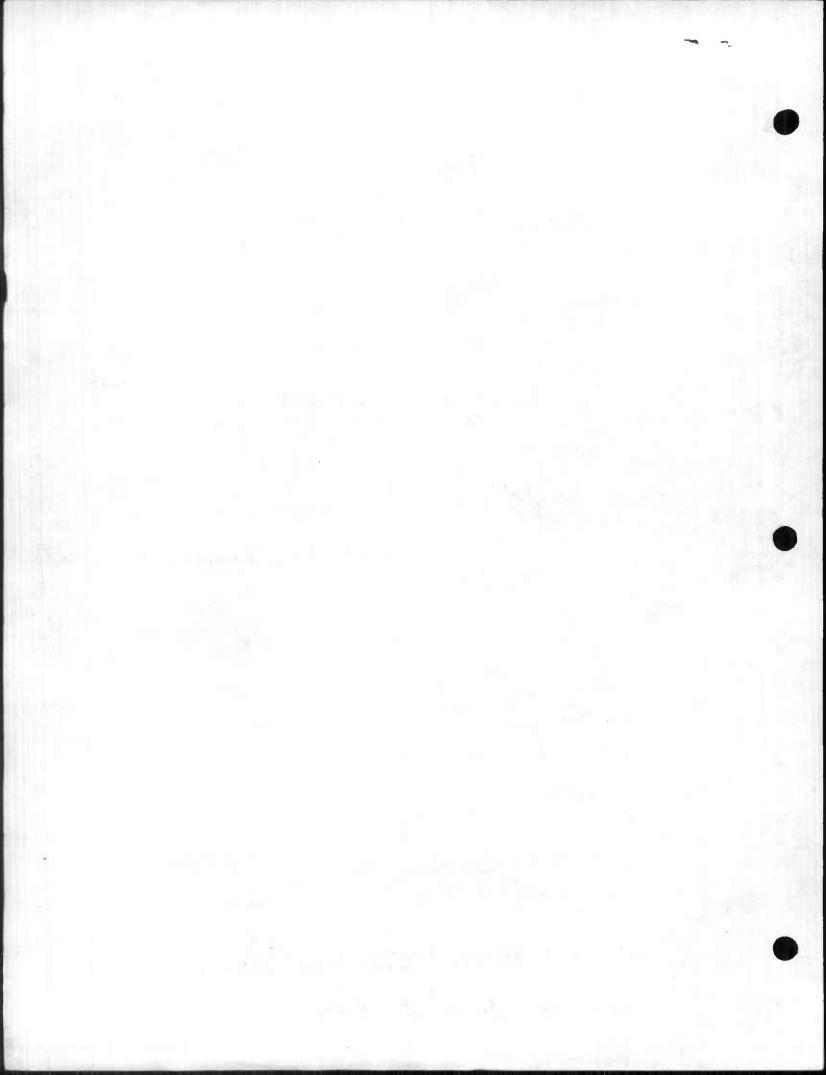
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier odical ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 176416 3 2000 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue MARIE Hagerstown, MD 21742 M.

State Registrar

31. Date filed (Month, Day, Year) AUG 0 3 2000

DHMH 16 Rev 6/95

32. Registrer's Signatu



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death **Physiclan** Yee TENTIMOE AR BULL Huous 17, 2000 4c. County of Death /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** LORIEN NURSING HOME FRANKFORD BALTIMORE n/a If Under 1 Months 5. Social Security Number 7. Age (In yrs. last birthdey) # Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthpiace (State or Foreign Country) Funeral Hours 1 M 20 F Yrs. Director 218-18-0688 91 9/8/08 MARYLAND Usuel Residence of Decedent r 28a-f show 10e. Stete 10b. County 10c. City, Town or Locetion 10d. Inside City Limits MD N/A Director BALTIMORE No Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is merked other than "natural", or items 23a or traumatic event, ma Medical Examiner rount be i 3941 SINCLAIR LANE 21213 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Yes 2 No à Specify. 3 Widowed 4 Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 10TH GRADE OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be LEWIS E. WELTY MATTIE B. BARRICK 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) TRUDY KEEFER GRANDDAUGHTER 3527 RIVER BRIDGE WAY other LAUREL, MD 20724 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Pages 1 mant of H ant: If Ite 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from Stete Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE CEMETERY 8/19/00 BALTIMORE, MD 22. Name and Address of Fecility
THE JOHNSON FUNERAL HOME, P.A. 21. Signeture of Fungral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medicai fmmediete Ceuse (Finel RENAL FA ILURG 554O disease or condition resulting In death) Examiner Due to (or es e consequenca of): Examiner KIDNEY 635TR UCTION ZYAC Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequenca of): BLADDER ANCIN UKNOWN Physician/Medical the Due to (or es a consequence of): 8(00) Q, ta) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be dateched 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24e. Wes an eutopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of deeth? CARLDIONYUSA VAY 2 DNO 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 28. Place of Death (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 3 4 Homicide 18 Certifying Physicisn: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es ststed.
2 Msdical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and plece, end due to the cause(s) and menner steted. 29e. Certifier Medical

29c. License number

41291

CROSS ROMAS

29d. Dete signed (Month, Day, Year)

Bucust 7

2000

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The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

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physician

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After

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after death Director:

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Maryland

Baltimore,

State Registrar (Check only one)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** AUGUST 2:45 P.M. 2000 Louise E. Adams 11 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner ROSEDALE BALTIMORE FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 4-23-1927 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2MF Months 231-28-0649 73 Yrs VA Director Usual Residence of Decedent the Meryland r 28a-f ahow 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Rosedale MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heelih and Mental Hygiene.

Important: If item 27 is marked other than "natural", or itema 23a or any injury or other thaumatic event, in the feet of the property or other thaumatic event, in the feet of the property or other thaumatic event, in the feet of the property or other thaumatic event, in the feet of the property or other thaumatic event, in the feet of the property or other thaumatic event, in the feet of the property or other thaumatic event, in the feet of the property or other thaumatic event, in the feet of the property or other than the property of the property or other than the property or other than the property or other than the property of the property of the property or other than the property or other than the property of the property or other than the property of the property or other than the property or other than the property of the property of the property or other than the property or other than the property of the property or other than the property of the 21237 411 Potomac Avenue USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Black, Whita, etc. 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify. à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home 0 Homemaker 10 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Eva Ester Evans Samuel Moore 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7924 35th Street, Baltimore, MD Geraldine Heise/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition important: If it any injury or o 1 ■ Buriel 2 Cremation 3 Removel from State 8-14-00 Baltimore, MD 4 ☐ Donetlon 5 ☐ Other (Specify) Garden of Faith Cem 21. Signature of Funerel Service Lice 22. Name end Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue, Baltimore, MD 21237 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) Medical END STAGE LIVER DISEASE MONTHS Examiner Due to (or as a consequence of) Examiner HEPATORENAL SYNDROME Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) physician the burial 68760. Physician/Medicai Due to (or as a consequence of) Box 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by 1 Yes 2 No 3 Probably 48 Unknown The law requires thet Records. þ 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Wes en autopsy performed? page 1 Yes 2 No 1 Tyes 2 No Division of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Yes ≥ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After or Attending 1XX Naturel 5 Pending Investigation 1 Yes 2 No death. 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completaly filled is Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and title of signifie 29c. License number 29d. Date signed (Month, Dey, Year) RD 188821 2000 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) GERRI DAVIS, MD 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD

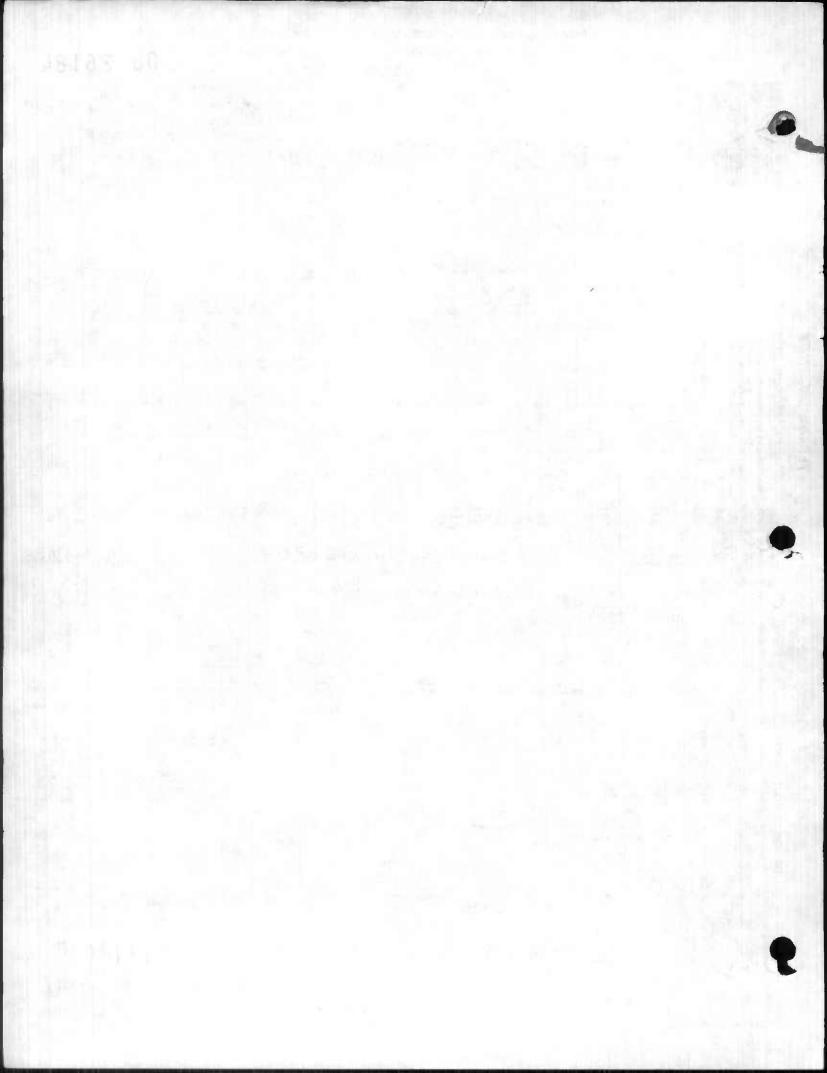
DHMH 16 Rsv 6/95

State Registrar

7 SINOT

ADAMS,

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Sara Arbesman 4b. City, Town, or Location of Death Jw D 12, /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth Octoor, Bay, 10008 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign VIROINIA **Funeral** Days Months Hours 214-22-4709 1□M 2♥F 91 Yrs Director Usual Rasidence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Depirtment of Heelih and Mentel Hydiene. The man 72 is marked other than "natural", or fierra 23a or 28a-f show may injury or other treumatic event, the ways. TENes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 5607 HIGHGATE DRIVE Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married TYPES 2 NO ARMY Specify:WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify py 3 Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Gollege (1-4or 5+) REGISTERED NURSE HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be NACHMAN REBECCA HARRY POLONSKY Lo 19a. Informant's Name/Relationship (Type, Print) GILBERT ARBESMAN/SON 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 5607 HIGHGATE DRIVE BALTIMORE, MD. 21215 20a. Method of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, State railed Emalery of other place) FRIEDEL MARYLAND LODGE Burial 2 Cremetion 3 Removal from State 8/15/00 ROSEDALE, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. ewiz 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, so on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final cardio hyppath disease or condition resulting in death) Examiner Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): physicien s the burial Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detact t Yes 2 No 3 Probably 4 Unknown STROKE Records, by 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 2 DENO 1 TYas 2 No certificate 1 Yes or Attending Physicien: funeral director. 25. Was case referred to medical examiner? 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ (Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deat 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 ☐ Suicide 6 Could not be detarmined 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randalle Town In Loregue

State Registrar

DHMH 16 Rev 6/95

P.O. Box 68760.

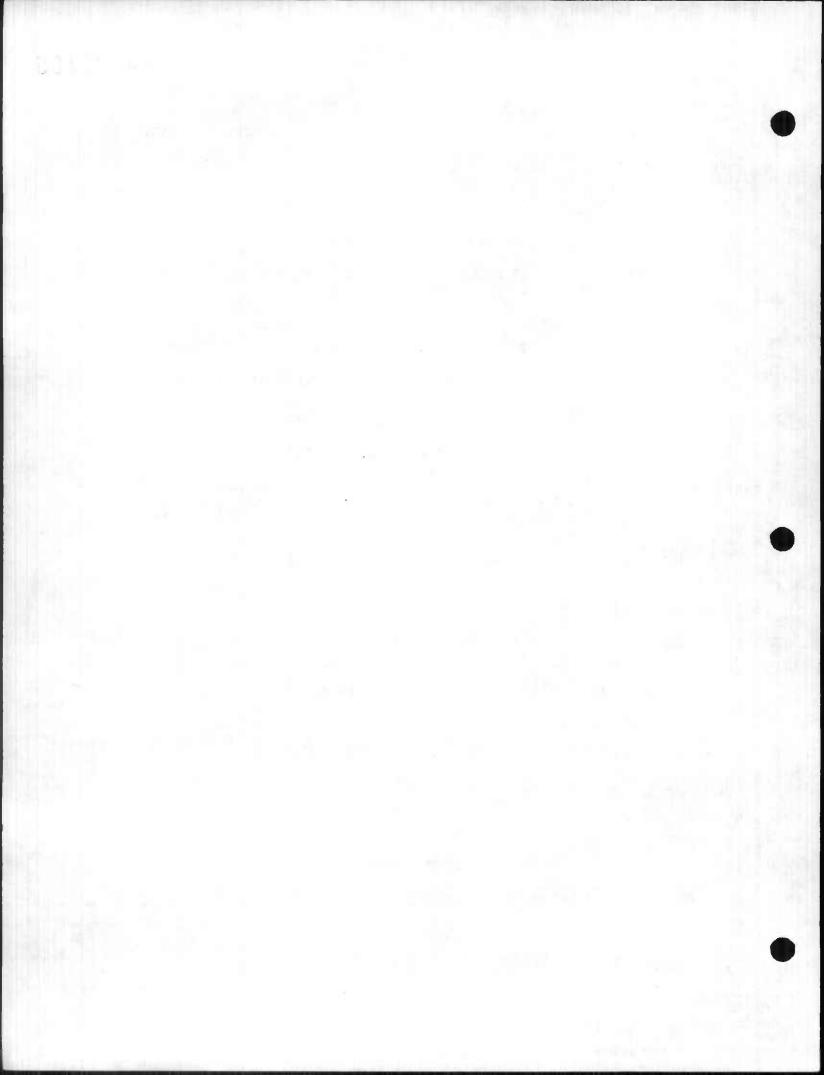
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AUG 1 8 2000 ---

31. Date filed (Month, Day, Year)

32. Registrer's Sign

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2. Date of Deeth

AUGUST

16 2000

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Approximete Interval Betw

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24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1. Decedent's Name (First, Middle, Last)

Elaine

Physician

/Medical

24e. Wes en autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated 29e, Certifier (Check only one) 29c. License number

29b. Signeture and title of certifier

RD203489

29d. Date signed (Month, Day, Year) 8/16/00

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

DRLISA Devente 9000 Franklin Square Drive Baltimore MD 21237

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

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State Registrar **DHMH 16 Ray 6/95**

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Division of Vitai Records,

Physician:

or Attending

funeral

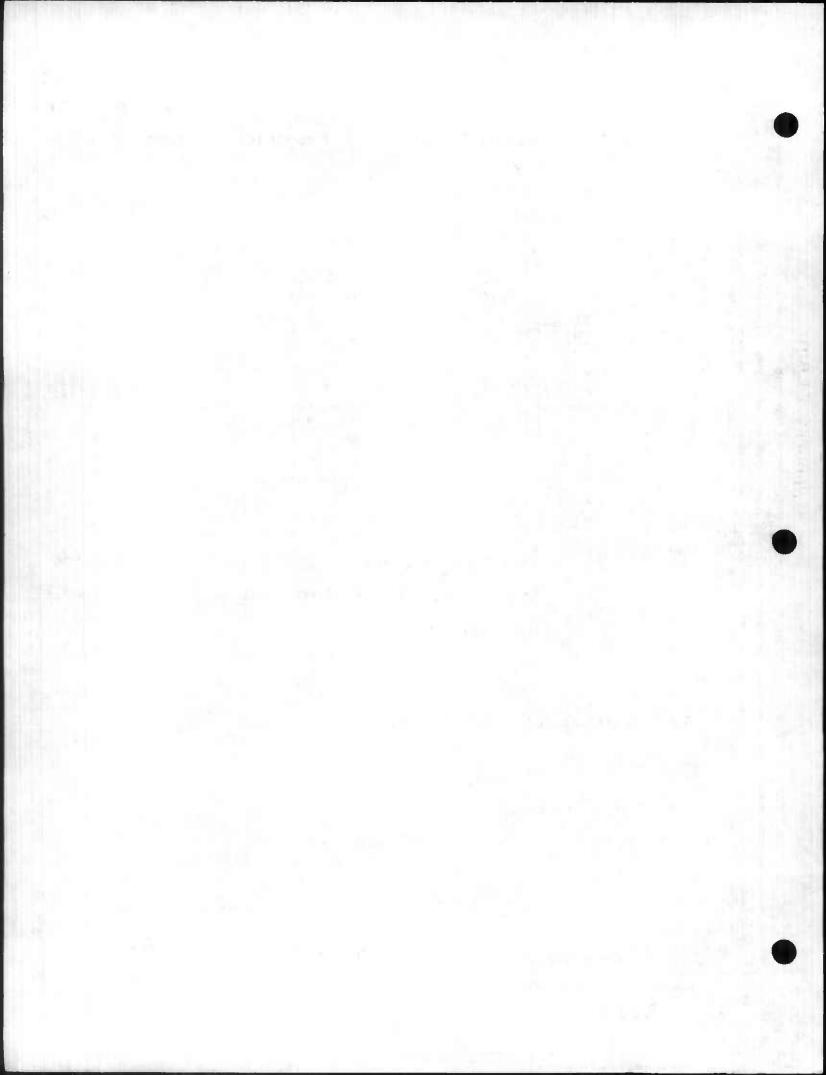
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To the Hospital o within 24 hours af To the Funeral Di

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State of Maryland / Department of Health and Mental Hygiene 26187 Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Rommell Brown III 9:20 pm Germaine August 13 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 8-13-2000 7. Age (In you last birthday) Birthplaca (State or Foreign Country) 100 M 2□ F Yrs. M.D. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XIXYes 2 No Baltimore Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 1107 Harwall Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 Yes 2 No Specify: Specify: þ 3 □ Widowed 4 □ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com Decedent's Usual Occupation (Give kind of work done during Sive kind of work done during most of working (e. DO NOT use retired) College (1-4or 5+1 Elementary/Secondary (0-12) N/A N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Julie Brooks Germaine Rommell Brown II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1107 Harwall Road, Baltimore Md Julie M. Brooks-Mother 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t X Burial 2 □ Cremation 3 □ Removal from State 8/18/00 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit March F/H West 21215 Markon 4300 Wabash Ave, Baltimore Md ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Congenital Anomalies 1 hour Due to (or as a consequence of): 1 hour Examine Possible Trisomy 18 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? tX Yes 2□No 1 N Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Minpetient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28tt. Injury at Work? Certification: 1 (X Natural 5 ☐ Pending 1□ Yes 2□No investigation 2 Accident 5 ☐ Could not be 3ITI Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D30206 August 15, 2000 tenes 6701 N. Charles St. 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) Baltimore MD 21204 Steven H. Pearlman, M.D. Greater Baltimore Medical Center

Registrar

Funeral

Director

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an "natural", or item Medical Examiner

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Department of Important: If It any injury or o ance.

Physician

Examiner

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physician a r the burial-

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Box 68760

Division of Vital Records, P.O.

/Medical

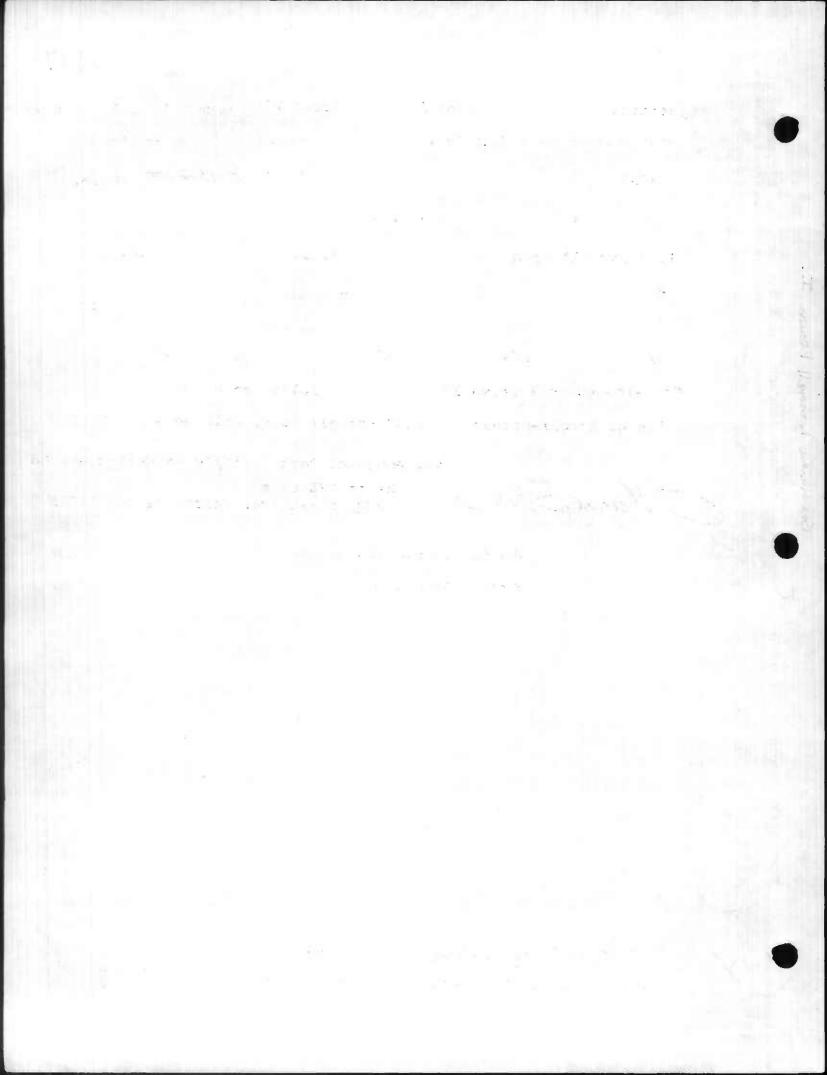
Pages 8

2

Sermaine Rommell Brown

32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 18 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#1 PER MD. G786 8-18-2000 JAB 2. Date of Death Day Month Year Physician 2000 Jarne /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of De 4c. County of Death Examiner Cita 5. Social Security Number 7. Age (In Vis. last birthday) H Under 24 Hrs. 6. Sei If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Director nknown nce of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Manyland any Injury or other treumatic every many injury or other treumatic every 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 10 Yes 2□No Director timore mi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 2/20 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian. Bleck, White, etc. 1 Never Married 2 Merried 1□Yes 20 No Specify by 3 ☐ Widowed 4 ☐ Divorced 1001 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA NIA NIA 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 80 Chown Jannes 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kisha M. 2/205 10. mother 20b. Plece of Disposition (Neme of cemetary, crematory or other Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 DRemovel from State 4 Donation 5 DiOther (Specify) DIS posq / 21. Signeture of Funeral Service License Evans 600 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failura. List only one cause on each line. Approximata Interval Between Onset and Daeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Re Examiner Due to (or as a consequence of): Examiner icien and burlei-transit or Attending Physician: The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. attending physicien for use as the burle Physician/Medical Due to (or es a consequence of): signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy tindings available prior to completion of cause of death? 24s. Was an autopsy performed? 20 No 1 Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To After this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

State Registrar

completely

29a. Certifie

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who com

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2000

DHMH 16 Rev 6/95

ed cause of death (Item 23a) (Type, Print)

1000 32. Registrer's Signetura

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

Egger Street, Reltimore my 2/201

2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BLAND NATHANIEL 14. 2000 AUGUST 5:27 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTON HSPITML 40NTHWEST CENTER BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birtholace (State or Foreign Country) **Funeral** Days 1 M 2□ F 13-30-5778 JUNE 12, 1936 VIRGINIA Director Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No Directo 288-1 MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ARDINAL 23a COURT 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married t□ Yes 28 No 21215-0020 "natural", or Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. a marked other than " umatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) ABORER BETHLEHEM STEEL ment of Health and Mental Hy rit: If flem 27 is marked other y or other trausaction Baltimore, Maryland 17. Father's Name (First, Middle, Last) UNKNO WN 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should VIRGINIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) N. BENTALOU STREET, BALTO, MD. 21233 ition (Name of Date 20c. Location - City or Town, State PAMELA SMITH (NEICE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ Removal from State 8-22-00 OWINGS MILLS, MA 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 22. Name and Address of Facility BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licenses 2140 FULTON AVE. BALTIHORE, MD. 21217 N 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MYOCANDIAL HOUR Examiner Due to (or as a consequence of) Examiner CORONARY DISEASE YEALS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s the burie HYPERTENSIVE Box 68760 CARDIOUASWUM DISEMSE Physician/Medicai Due to (or as a consequence of): USB Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4€ Winknown PIABETES MELLINS by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed UASCULAR 1 ☐ Yas & No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 200 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred

Division of Vital Records, or Attanding Physician: After this death.

24 hours after death Hospital compietely Within 2 \$

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State Registrar

Medical

AUG 1 8 2000

5 Pending investigation

6 Could not be

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30. Name any address of person who completed cause of death (Item 23a) (Type, Print)

My

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and July of g

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31. Date filed (Month, Day, Year)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5401 OLD COUNT ROAD

1 Yes 2 No

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

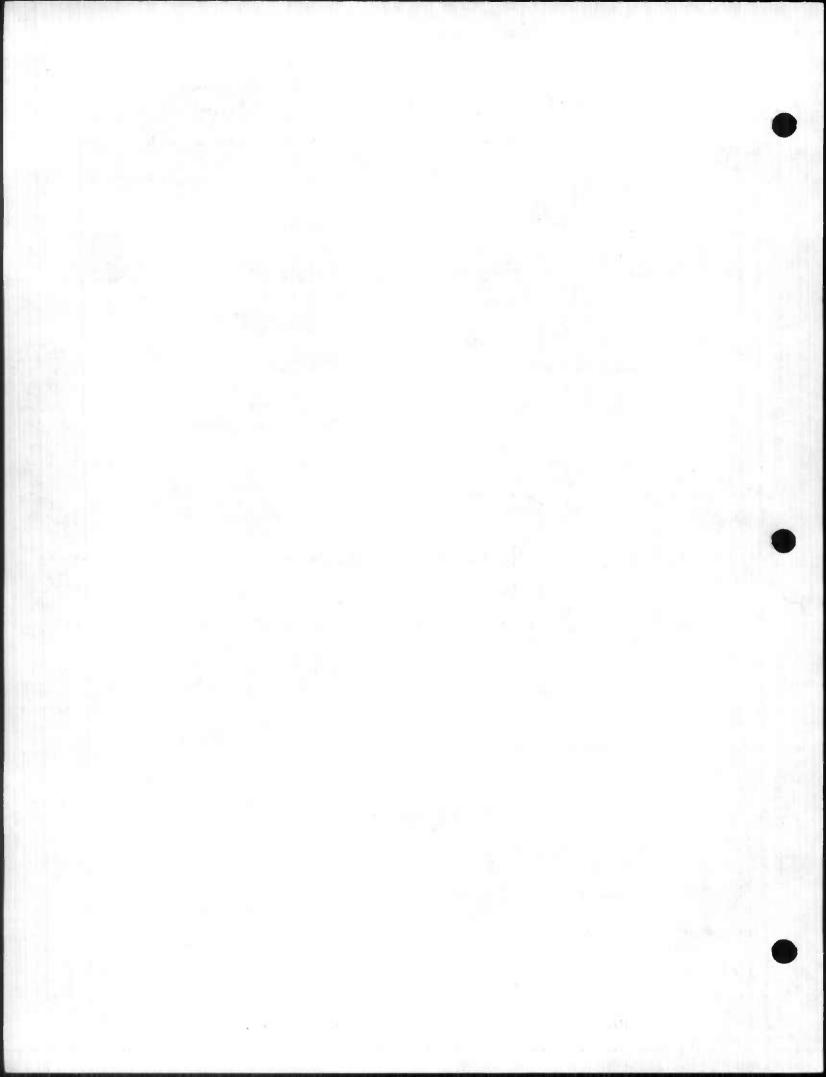
28f. Location (Street and Number or Rural Route Number, City or Town, State)

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29d. Date signed (Month, Day, Year)

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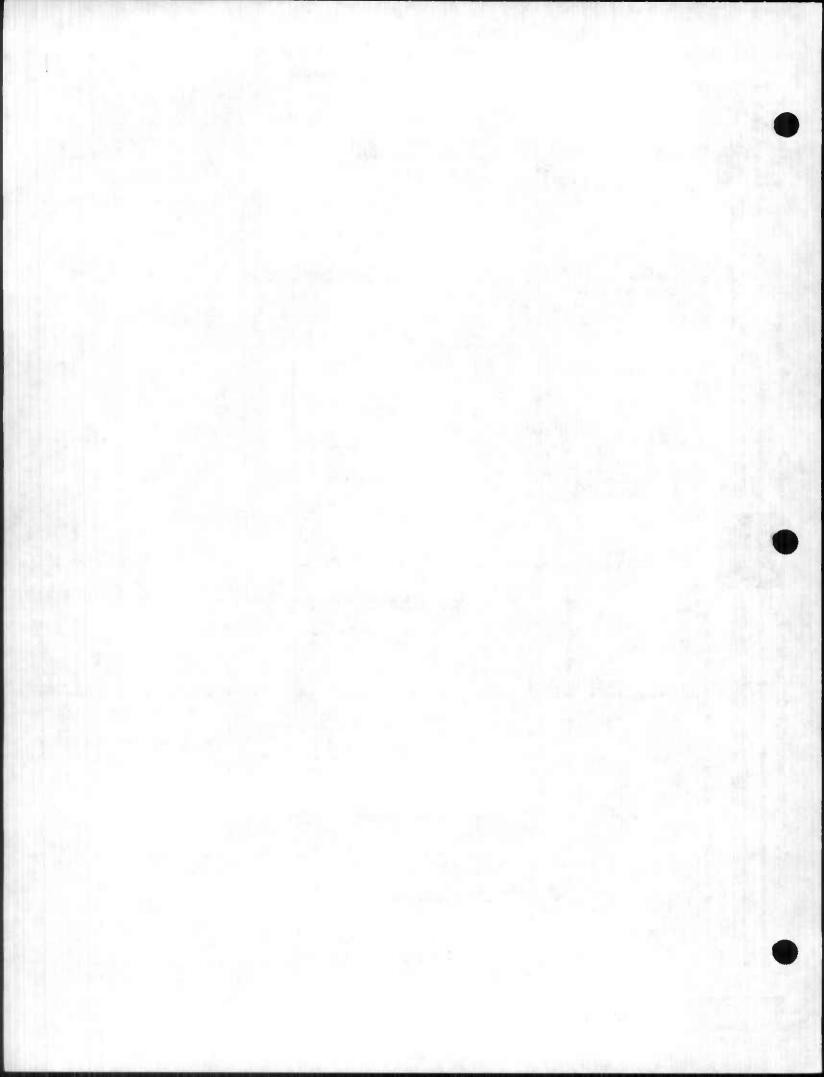
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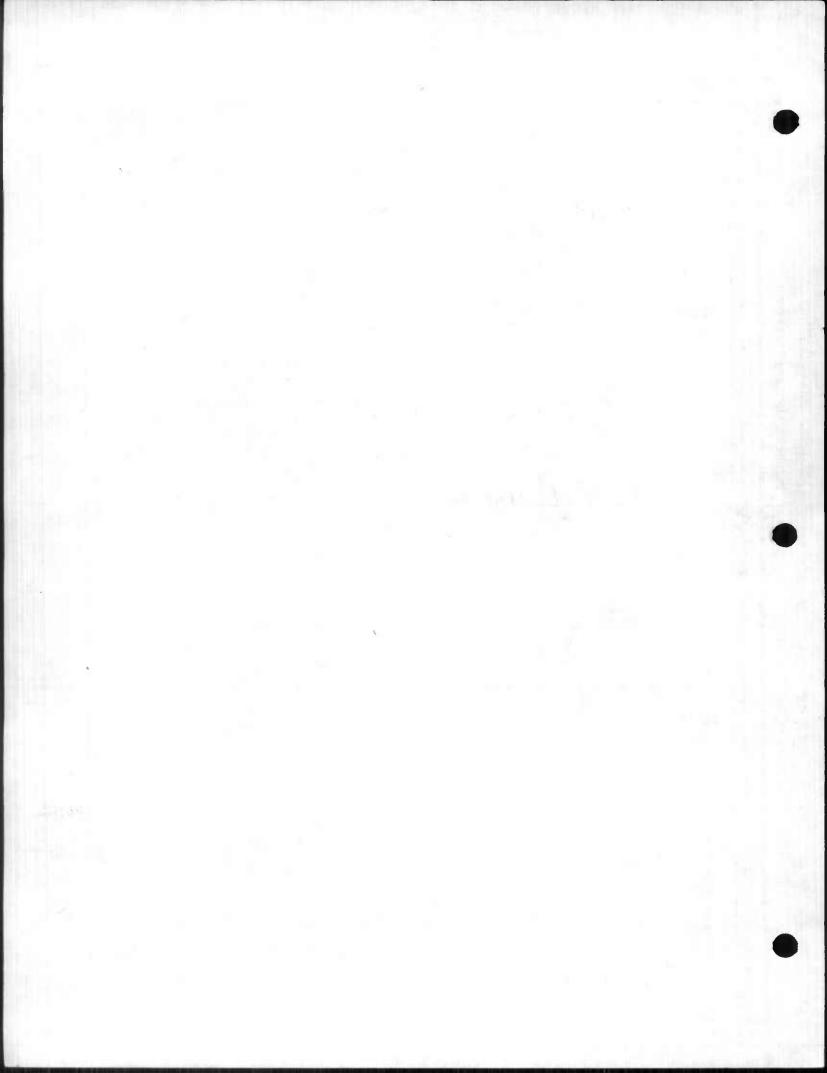
State of Maryland / Department of Health and Mental Hygiene 00 26 191

			Cer	tificate of	Death		Re	ig. No.	5 6	0191
-1.	1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month	Dev	Yeer	3. Time of Death
Physician /Medical	LOIS MARJORIE N	MARTIN BARTON	Ī					11, 200		7:00 A.M.
Examiner	4a Facility Name (If not institution, give str	eet and number)			4b. City, To	wn, or Lo	cation of Deeth	4c. County	of Deeth	
82	EDENWALD				Tow			Baltin		County
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs.		Months Days		24 Hrs. Min.	8. Dete of Birth (Month, Dey,		9. Birthpla Counti	aca (State or Foreign ry)
Director	213-48-6609	89 89	Yrs.				Nov 17,	1910	Michi	gan
I	Usuel Residence of Decedent 10e. Stete 10b. County	10c. Cit	y, Town or Loc	cation					10	d. Inside City Limits
Alanyta Alanta Alanta Or		C- 1	n							1 ☐ Yes 2 No
the hours	Maryland Baltimore	County	Cowson	10f. Zip Code			10	Og. Citizen of V	/hat Count	N?
Dir	800 Southerly Roa	d			1286				SA	
na 23 mas 23		. Wes Decedent Ever in U.	.S. 13. V	Vas Decedent of Yes, specify Cu		gin? (Spe	cify Yes or No-		- America	n Indian,
Turn Marie	1 Never Married 2 Merried	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give				, Puerto	Rican, etc.)	Blac	k, White, e	tc.
d within 72 hours at years. or than "natural", or the Medical Exam.	3 ¼ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:			Specify	: Wh:	ite
ted galler	15. Decedent's Educa	tion	16a. Deced	ent's Usual Occu	upation	t a f ward i		16b. Kind of Bu	siness/Indi	ustry
Med ald	(Specify only highest grade of Elementary/Secondery (0-12)	College (1-4or 5+)	life. C	OO NOT use retir	e <i>aun</i> ng mosi red)	OF WORK	ng			
od within yglene. vr. the Man t, the Man		4+	Homem	aker				Own 1	Resid	ence
d be file of be file and othe c event,	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle, A	feiden Sumem	Θ)	
	Charles W. Martir				l I	da		Eie	cher	
A Sahou A Sahou B and M T is ment traument	19a. Informent's Name/Relationship (Type	(Dghtr)	19b. Mailin	g Address (Stree	et end Numbe	er or Rure	i Route Number,	City or Town,	Stete, Zip	Code)
- 5974	Marjorie Price Bart		2360	Flax Te	rrace,	Ba1	timore.	Maryla	nd 21	209
1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Rer		Place of Dispos semetery, cren	sition (Neme of netory or other pl	lece)			20c. Location -		
mil. Pages 1. partment of Hs portant: if her y Injury or oth	4 ☐ Donation 5 ☐ Other (Specify)	Dr	uid Ric	ige Ceme	tery	18	/17/200	O Pikes	ville	, Marylan
S Indiana	21. Signature of Funeral Service Learning			. Name and Add				**	ng-	
0 88558	Martin B. Lawso	ulum	M	itchell.	-Wlede	Teld	Funeral	. Home,	Inc.	1010
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	tions that caused the deat	h. Do not ente	er the mode of dy	ying, such as	cardiec c	or respiratory arre	est,	and -	1212 Approximate Interval Between
Physician	Stock, of floor, failure. Elst only one	,							1	Onset and Death
/Medical	Immediate Causa (Final disease or condition	1-11	me,	Con	yen.					Zyrs
Examiner	resulting in death)	Due to (c	or as a conseq	uenca of): /		11.	T +-	home	2	
executed n and selfransit		CON	NH	Chro	me	000	untille	drot	noi	(yn
and Hrans Xami	Sequentially list conditions, if any, leading to immediate	Due to (o	or es e conseq	uenca ol);	0	1				11.
ou, oe ex clan clan suite E	Cause (Disease or Injury	47	Loro	schri	tre 1	de	senso			1020
ficate be of physician is the bun edical I	thet initieted events resulting in death) Last	Due to lo	r es e consequ	uence of):						
. 2 6 5	d.,									
BOX Beth cer for use clan/A										
requires that the deeth ce requires that the deeth ce een signed by the attendi hould be detached for uss eted by Physician/	Part II. Other significant conditions contri	buting to death but not res	ulting in the ur	nderlying cause g	given in Pert I					the cause of death?
P detay							1 🗆 Y	ee 2□ No	3 Prob	ably 4 Unknow
The law requires that the law requires that the has been signed to page 2 should be det.							24e. Was a	o autoney	24h We	re autopsy findings
should should							perform		ava	llable prior to
o law has b ge 2 s									of d	leath?
The I							1 □ Ye	2 200	1 [Yes 2□ No
yelcien: Thy gractor, pag fo Be Co	25. Was case referred to medical examiner?	spital:				of Deat	(Check only on	e) (
T digital	TLI Yes ZLIGHO	1 L Inpatient 2L	ER/Outpetien	t 3LI DOA		-	me 5 Reside)
on o ding Ph h. After th funeral	27. Menney of Death 1 Natural 5 Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	W			28d. Describe how injury occurred			
OIVISION or Attanding after death. Director: After of in by the fune ertification	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2		204 Location /Or	and and Mumb	as as Rusa	Coute Number
Pr Ar Her of History in by in by in the control of	4 ☐ Homicide determined	28e. Plece of Injury - At he building, etc. (Specif.	ome, farm, stre	eet, factory, office	е		28f. Location (St City or Town	reet and Numb n, State)	er or Hure	Houle Number,
bilding of Attanding P on Attanding P on Attanding P on Attanding P of the										
Hosp 14 ho Funs Tely f	(Check only Medical Examine	lan: To the best of my kno r: On the basis of examine								
To the Hospital or Attant within 24 hours after deat completely filled in by the Medical Certifical	29b. Signature and title of certifier	and menner steted.	-94	29c 1 ices	nse number		2	9d. Dete signe	d (Month I	Day, Year)
PAN 8	1/1		1.	D	50	-	19	8-1	111	10
	1 //	myp	my Cu	and /	14	/	6	0/	17	10
2	30. Name and address of parson who com									
1	Marcelino D. Albu			therly	Road,	Tows	on, MD 2	1286		
State Registrar	31. Date filed (Month, Dey, Year) AUG 1 8 200	32. Registrer's Signa	2/ /	las	/					

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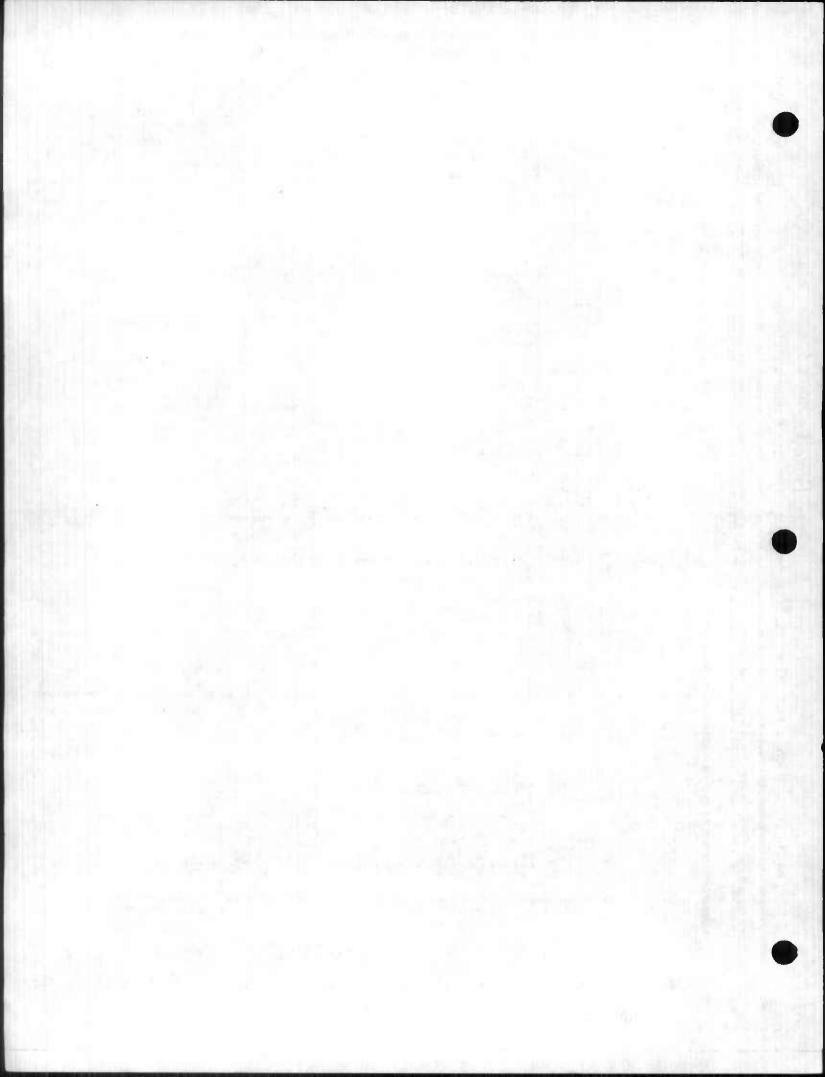


			Cei	rtificate of	Death		Reg. No.	UZ	0192
hysician	Decedent's Neme (First, Middle, Lass Steven Wayne Ber		.3-11-			2. Date of D Month	Day	Year	3. Time of Death
Medical						August		000	1:32 pm
xaminer	4a Facility Name (If not institution, give Stella Maris Hosp	· ·			4b. City, Town, or L. TOWSOI		,	of Death Ltimore	2
eral ctor	5. Social Security Number 6. S		yrs. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Dete of B (Month, D	irth ay, Year)	9. Birthplac Country	ce (State or Foreign
.01	Usual Residence of Decedent	10				Dec.	21, 1931	Virgi	ınıa
with the Maryland a or 28a-1 show Libe notified at Director	Maryland Baltimor		City, Town or Lo					10d	. Inside City Limits 1 ☐ Yes 2 No
Directo	10e. Street and Number 212 Stevens Rd.			10f. Zip Code 212	20		10g. Citizen of USA		?
of a should be filed within 72 hours after death of 2 should be filed within 72 hours after death of 1 is marked other than "natural", or farms 23 treumetic event, the Medical Examiner must To Be Completed by Funeral	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ②Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto Specity:	pecify Yes or N Rican, etc.)		ee - American ck, White, etc y: Whit).
pete	15. Decedent's Ed (Specify only highest gra-	ucation	16a. Deced	dent's Usual Occu	upation e during most of work	tina	16b. Kind of B	usiness/Indus	stry
Completed	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	life. I	DO NOT use retin	ed)	g			
	12 17. Father's Neme (First, Middle, Last)		Ca	arpenter	18. Mother's Nem	a /First Middle		ruction	1
To Be	George Benson				Thelma	Little			
	19a. Informent's Name/Reletionship (1) Richard W. Benson		19b. Meilir 1153	ng Address (Stree 7 Frankl	inville Ro	al Route Numi	ber, City or Town, r Falls,	State, Zip Co	ode) 21152
	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Specify	Removel from State		netory or other pl	atory 8/18	Dete 3/2000	20c. Location -		
	21. Signetare of funeral Service Licen	3 R R		Name end Addr	ski Funera	al Home	P.A.		24
	23a. Part Enter the disease, or comp	wikousk			Eastern A		•		221
edical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.								
Medica	Cause (Disease or Injury that initiated events resulting in death) Last		to (or es a conseq	uence of):					
lan/		d						1	•
Physician/	Pert II. Other significant conditions co	entributing to death but not	t resulting in the u	nderlying cause g	iven in Pert I.		Yea 2 No		ne cause of death bly 4 10 Unknow
Completed by						24e. We per	s an autopsy ormed?	availe	autopsy findings able prior to pletion of cause ath?
E O						10	Yes 2 No	101	/es 2□ No
Be	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only	one)		
To the Houptial or Attending Physician: The I within 24 hours after death, which 24 hours after death, routhe Funerel Director; After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	1 ☐ Yes 2 📉 No		2 ER/Outpatien	1 3LI DOA			idence 6 X Oth		HOSPICE
	27. Menner of Death 1 Netural 5 Pending 2 Accident Investigation		28b. Time of Injury	W	ury et ork?] Yes 2 [] No	28d. Describe	how injury occur	red	
Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, ferm, str pecify)	eet, fectory, office			(Street and Numl own, State)	ber or Rural F	Route Number,
edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	reician: To the best of my iner: On the basis of exar and manner stetect.	knowledge, death ninetion and/or inv	occurred at the trestigetion, in my	time, dete and place, opinion, deeth occur	and due to the red et the time	cause(s) and ma , date end piece,	anner as state and due to th	ed. ne cause(s)
2	29b. Signature and title objectifier	/_			nse number		29d. Date signe	d (Month, Da	y, Year)
\	1			\mathcal{D}	143721		8/17	1/00	
1	30. Name and address of person who could be a series of person of		(Item 23a) (Type,		TIMONIU	M MD 5	21003		
State	31. Date filed (Month, Day, Year) AUG 1 8 2	32. Registrer's S	igneture	Loo	e Ka	المراز والم	1033		
strar	MAG T O C	000	/	1	1700				



amend item	7 per fh G786 8/21/00 y	State of Maryland	/ Departm			nd Mental H	ygiene 0	26193	
Physician	1. Decedent's Nama (First, Middle, Last					2. Data of I		Year 9000 4.32 pm	
/Medical Examiner	James Edward 4a Facility Name (# not institution, give	Biglen street and number) re 1-105 pital	Canta	_	4b. City, Town Rose	n, or Location of De	ath 4c. County		
Funeral	5. Social Security Number 6. Se		st birthday) If U	ndar 1 Yaai iths Days	If Under 24	Hrs. 8. Date of E	lirth Dey, Year)	Birthplace (State or Foreign Country)	
Director	Usual Residence of Decedent	72	Town or Location			August	2, 1930	Pennsylvania 10d. Inside City Limits	
a-f show affind at otor	Maryland Baltimo	1 Yes 2 No							
vim the Ma t or 28s-f t be notified Directo	10e. Street and Number			. Zip Code			10g. Citizen of \		
her deam v r hems 234 siner must Funeral	3212 Everlasting	Lane 12. Was Decedent Evar in U,S		21220 recedent of	Hispanic Origin	n? (Specify Yes or I	U. S. 14. Rac	A . a - American Indian,	
Maryland 21215-0020 d 2 should be filed within 72 hours after of th and Merital Hygiens. T is marked other than "natural", or then traumetic event, the Medical Examinat To Be Completed by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas?	If Yes,	specify Cul	ben, Mexican, I	Puarto Rican, etc.)	Specify	ok, White, etc. White	
ed within 72 ho vglene. ver than "naturn it, the Medical.	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Decedent's	Usual Occu of work done OT use retin	during most of	of working	16b. Kind of B	usiness/industry	
Hygien Hygien ther th ent, the	12 17. Fathar's Name (First, Middle, Last)		Supervi	sor	18. Mother's	s Neme (First, Midd		ng Industry	
Mental H Mental H rrked off affic ever To Be	William Bigle	en			Dori		grove		
2 ah	19a. Informant's Name/Relationship (T)					or Rural Route Num			
t of Health If Item 27 or other t	Diane Biglen (With 20a. Method of Disposition	20b. Pla	3212 Et ce of Disposition netery, cremator)	(Name of	sting L	Date		MD 21220 City or Town, State	
mit. Pages 1 ar partment of Hea portant: If Item; y Injury or other c6.	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	GLCC	en Mount		atorium ess of Facility	8618	Baltim	ore, Maryland	
2012	0526		Bruze	dzins	ki Fune	ral Home	PA	1 1 04 004	
Physician /Medical Examiner	23a. Part / Enter the disease, or comp shock, or heart failura. List only o fmmediete Cause (Final disease or condition resulting in death)	disease or condition IVETASTATIC PROSTATE CANCER							
and I-transit xamin	Sequentially list conditions, if any, leeding to immediate cause. Enter Undarfying Cause (Disease or injury c.								
die the	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of):								
the atter thed for the	Part II. Other significant conditions con	ntributing to death but not result	ing in the underly	ing cause g	iven in Part I.	23b. D	d tobacco use co	ntributs to the causs of death?	
igned by the be detached by Physic		Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.					1 Yes 2 No 3 Probably 4 Unknown		
been s should should						24e. W	as an autopsy rformed?	24b. Were autopsy findings svallabla prior to completion of cause of death?	
						10	Yas 200 No	1 □ Yes 2 □ No	
ystcien: The secreticate director, pag	25. Wes case referred to medical examiner?	Hospital:		- 10	a b	of Death (Check on)			
hys his aldi	1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation	12(Inpatient 2LE	R/Outpatient 3[28b. Time of Injury	28c. Inj	4 LI Nurs	28d. Describ	Home 5 ☐ Residence 8 ☐ Other (Specify) 28d. Describe how injury occurred		
2442	3 Sulcide 6 Could not be 4 Homicide determined	9 One Place of Injury At home from extent factors office			28f. Location	(Street and Numi rown, Stete)	ber or Rural Route Number,		
Hospi 24 hou Funer Itely fill	29e. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best of my know ner: On the basis of examination and manner stated.	edge, deeth occu on and/or investig	rred at the tation, in my	time, date end opinion, deeth	place, and due to the control occurred at the time	e cause(s) and me, date end placa,	anner as stated. and due to tha cause(s)	
within To the comple	29b. Signature and title of certifier				nse number		29d. Date signe	d (Month, Dey, Year)	
	A Jan Card	ler	A 7 -	KD,	20337	2	AUGUST	16,2000	
1401		an-Carden	9000 F	-		quale Dri	re Balti	more MI) 21239	
State Registrar	31. Date filed (Month, Day, Year) AUG 1 8 2000	32. Aegistrar's Signatu	P A	sout.	3				

DHMH 16 Rev 6/95



JOEL BRATTON

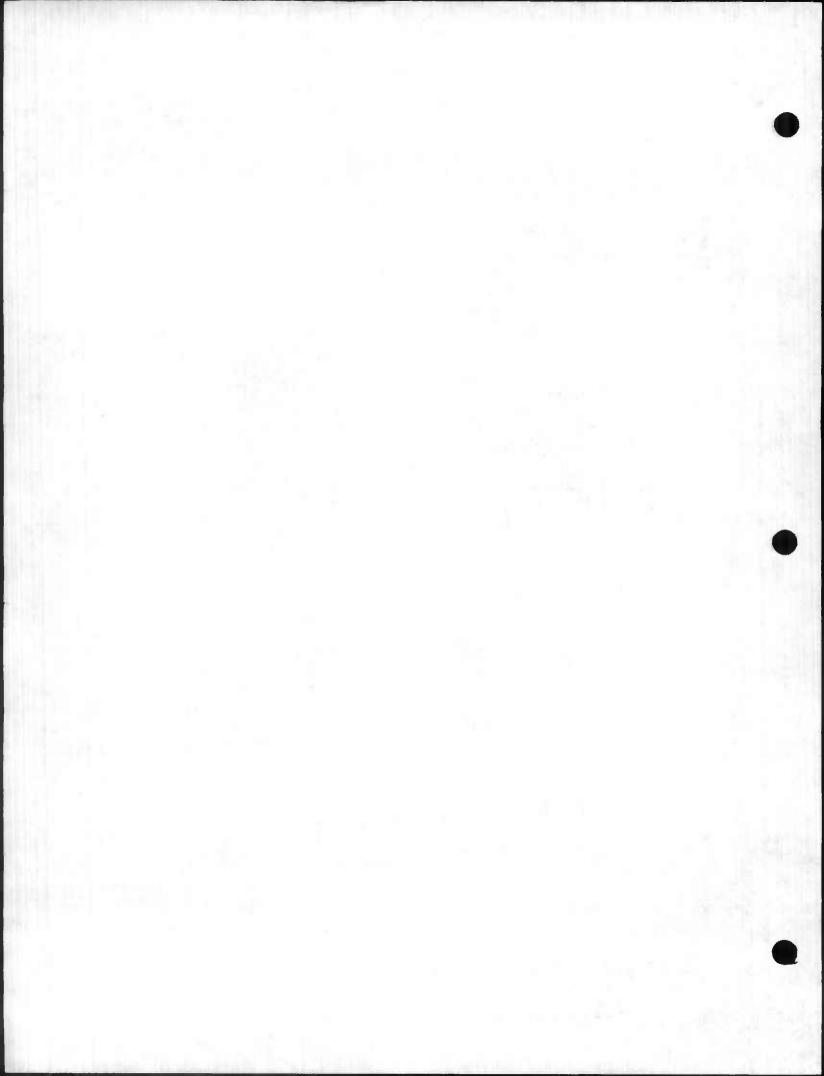
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dev **Physician** 10, 2000 4c. County of Death Joe 1 Bratton, Jr. AUG 3:30 AM /Medical 4a Facility Neme (If not institution, give street and number)
SHOCK TRAUMA 4b. City, Town, or Location of Death Examiner BALTIMORE n/a If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 6. Sex 1X M 2□ F 5. Social Security Number 7. Age (fn yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Yrs. 212-90-6479 35 Director July 7, 1965 Maryland Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov notified at 1 N Yes 2 □ No Director MD n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 r than "natural", or hams 23s or the Medical Examiner must be 1111 Sheilds Place Funeral 21201 USA death 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11 Marital Status Bleck, White, atc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced **Black** Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Millenium of Franklin mentary/Secondery (0-12) College (1-4or 5+) 12th Grade Square Nursing Home Housekeeper 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be nent of Heelth and Mental int: If Item 27 is marked o and Mental Joel Bratton, Sr. Betty Holliday 19a. Informent's Neme/Reletionship (Type, Print) mother 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Betty Abdul-Ali 1111 Sheilds Place Baltimore, MD 21201 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Department of Important: If it any injury or o page. 1 XBuriel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park Aug 12 Baltimore County, MD 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216 21. Signeture of Funeral Service Licen the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, 23e. Part 1. Enter the disease, or complications the causes to shock, or heart feilure. List only one ceuse of each line Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical wounds · Multiple gunshat Examiner Due to (or es a consequence of): Physician/Medical Examiner The lew requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest attending physician end for use as the buriel-tran Due to (or es e consequenca of) Box 68760. Due to (or es a consequenca of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contributs to the cause of death? 8 been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown of Vitai Records. p 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy performed? page 2 should Completed certificate hes 1. Yes 2 □ No 1 Yea 2□ No Physician: 8 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 17 Yes 2 No 10 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? Division or Attending 5 Panding investigation Shot 1 Netural subject was 1 Yes 2 No 8-10-2000 unknown 2 Accident 6 Could not be determined Location (Street and Number or Aural Route Nymber, City or Town, State) 782 Linand Street 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. 4 Momicide Sidewall Bultimore City, Mary land

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es stated. To the Hospital within 24 hours a To the Funeral C completely filled edical 29a. Certifier Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier O.C.M.E AUG. 10, 2000 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) Stephen S. 12a 31. Date filed (Morry 1998 2000 12 adent 2 111 2000 32. Registrer's Signeture 111 Penn Street, Baltimore, Maryland 21201 State oaks

Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day **Physician** Pearl C. Brackett August 14 0730 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore n/a If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year Birthplaca (State or Foreign Country) 7. Aga (fn yrs. last birthday) **Funeral** 10 M 205 Months Days 212-36-8985 83 Yrs. 6, Director Jan. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show Md. n/a Baltimore Yes 2 No the Medical Examiner must be notified Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4100 N. Charles Street Unit 704 21218 USA Funeral 12. Was Decedent Ever in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11 Marital Status Black, White, etc. 1 Yes 2 No If Yas, Give Year or Datas: 1 Never Married 2 Married Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 ☐ No Specify: Py d 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City filed within Hygiere. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Educator 17. Father's Nama (First, Middla, Last) UNKnown 18. Mother's Name (First, Middle, Maiden Surneme) should be trud Mental 1 Rosina Thompson and N 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) Pages 1 and 2 Department of Health as Important: If Item 27 is any Injury or other tran 2003s. Lydia W. Mussenden friend 4100 N. Charles Street Unit 1114Balto. Md. 21218 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a Method of Disposition Qurial 2 Cremation 3 Removal from Stata Arbutus Memorial Park Aug. 18 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Tutter Gerber 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 40 hours a intravarial hemorrhage with compression of brainston Examiner through feather magnin Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequenca of): use as the burial-trar Box 68760. Dua to (or as a consequence of): of Vital Records, P.O. Part ft. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown g 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 should Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certificat completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No edicai Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 14, 2000 runas habers mo AU 4176435L 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

Thomas

31. Data filed (Month, Day, Year)

AUG 1 8 2000

32. Registrar's Signatura

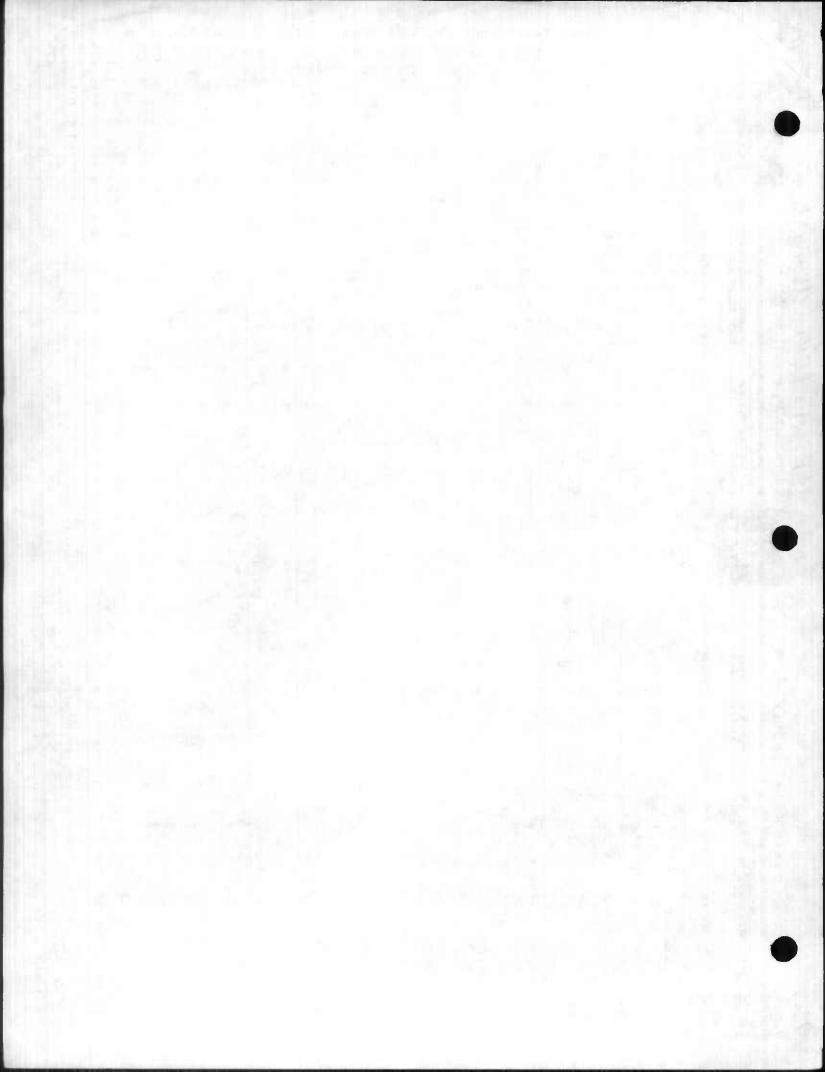
M.D. 4216 Sugar Pine Court, Burtonsville, MD 20866
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1 Decedent's Nama (First Middle Last. 2. Data of Death 3. Time of Death **Physician** 2000 9:12 PM Elaine Olga Breen 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) **Examiner** Towson
If Under 24 Hrs. Gilchrist Center Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Houra 1□M 2√F Yrs. 74 Director 216-20-1787 Usual Residance of Decedent Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inaide City Limits 1√2 Yes 2 □ No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 143 W. Hill Street 21230 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yea 2 ☑ No If Yes, Give △ Year or Dates: 1 Never Married 2 Married 1□ Yes 2√2 No Specify Specify: þ White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) 5+ Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumama) George Niebuhr Erna Degler 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Item 27 Martin Stephen Breen/Son 51 Reed Road Oakdale, CA 95361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc. 8-17-00 Baltimore, MD 21. Signature of Funeral Service Transport

Dawn 1 Clonald 22. Nama and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart tailure. List only one causa on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) menth Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Yea 2 No 3 Probably 4 Unknown of Vital Records, Medical Certification: To Be Completed by page 2 should be 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No s after death.
I Director: After this od in by the funeral d 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 13 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. Licanse number 29d. Date algned (Month, Day, Year) 29b. Signature and title of certifie mo 30. Name and address of person who completed cause of deat? (Item 23a) (Type, Print) Charles St. Balto. Md 6701 32. Registrar's Signature State Registrar **DHMH 16 Rev 6/95**

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician Barbara Nell Custer** 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not Institution, give street and number) Examiner **Baltimore City** anes If Under 1 Yeer 8. Dete of Birth Month, Dey, Year November 18, 1934 5. Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours Min. 1 M 2 F 245-46-7921 **Director** North Carolina Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 1 ☐ Yas 2 X No Directo Catonsville Maryland **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 21228 U.S.A. 238 2 Glencoe Ave Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritat Stetus 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify. White by 3 Widowed 4 Divorced Completed 16s. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Home Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 18. Mother's Neme (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be fill tower of Health and Mercal H tant: If less 27 is marked off jury or other traumstic even Be Nina Launia Spivey James Webb P 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Glencoe Ave Catonsville, Maryland 21228 Husband Mr. Gary A. Custer 20b. Plece of Disposition (Neme of cemetery, cremetery or other pl 20c. Location - City or Town, State 20e. Method of Disposition cemetery, cremetory or other plece)
Lakeview Memorial Park 1 ☐ Suriel 2 ☐ Cremetion 3 ☐ Removel from State 08/14/2000 Sykesville, Maryland Important: any injury o 4 Deorlation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. Lint only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical nmediete Cause (Final iseese or condition resulting in deeth) **Examiner** Physician/Medical Examiner myocades Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 2 weeks Due to (or as a consequence of) the Vears Custer, Barbara Pert It. Other significant conditions contributing to death but not resulting in the underlying cause, given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown been signed by t should be detact Hypertension PV 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Be Completed Cerebrovascular accident Rheumatic heart disease 1 Yes 1 Nes 2 No 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No after death. investigetion Director: / 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Funeral I 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29e. Certifier To the Ho within 24 h 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier D0056143 hu 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AGNES HOSPITAL , BALTIMORE, MARYLAND RAYMOND WEIMIN 31. Dete filed (Month, Dey, Year) AUG 18 32. Registrer's Signeture State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day **Physician** August 15, 2000 Olevia A. Cherry /Medical 10:05 a.m. 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Rossville Baltimore Manor Care If Undar 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 10 M 204 Months Yrs. 89 Mar. 27, 1911 Director Maryland 214-84-6536 tha Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "naturel", or items 23a or 28a-f ehow edical Espainer reset be notified at 1 Yas 2 No Directo Maryland Baltimore Middle River 10e. Street end Number 10f. Zlp Coda 10g. Citizen of What Country? 2124 Oakland Road 21220 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - Amarican Indian, Bieck, White, atc. Pages 1 and 2 should be filed within 72 hours aftar next of Haaith and Mental Hygiana. 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify. þ 3 ₩ Widowed 4 □ Divorced White Completed traumatic event, the Medical 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry marked other than Elementery/Secondary (0-12) College (1-4or 5+) Home Maker 12 Own Home Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Be Lewis K. Heck Mary F. Patterson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 2124 Oakland Road, Baltimore, Maryland 21220 Alan E. Cherry (son) important: If hem 27 any injury or other to 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Ramoval from Stata Holly Hill Mem. Gardens 8/19/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Address of Eacility
Bruzdzinski Funeral Home, P.A. 21. Signature of Nuneral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 disease, or complications that causad the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, heart failure. List only one cause on each line. Physician Immediate Cause (Final /Medical 3 Mos disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Box 68760, Dua to (or as a consequance of): signed by the a P.O. 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings aveilable prior to completion of cause of death? should b Completed 24e. Wes an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 10 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Waller S □ Residence 6 □ Other (Specify) funaral 28a. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 5 Pending investigation s after death. Il Director: Aff 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 8 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Spacify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dil complataly filled in Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) and manner stated. 29e. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yaer) CO 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Mohamed Rahnama, 19 Fontana Lane, Baltimore, Maryland 21237 32. maistrack Signeture 31. Data filed (AUG 2. 8ar 2000 State

Registrar

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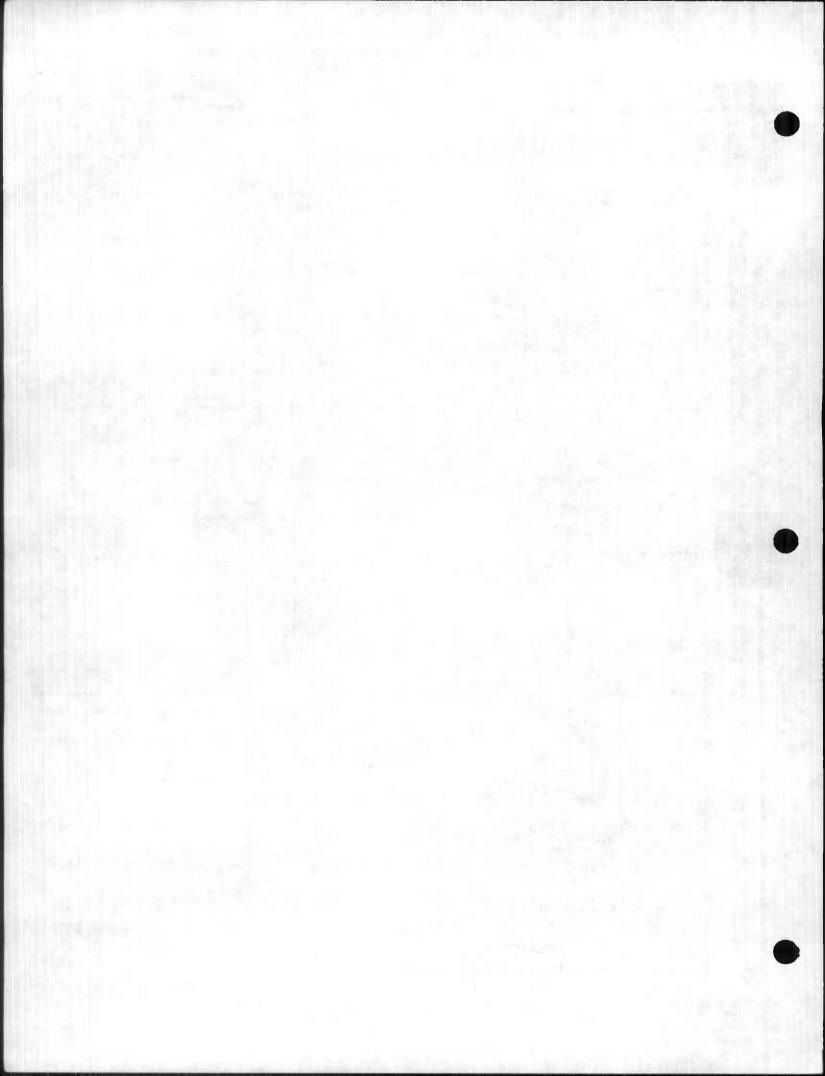
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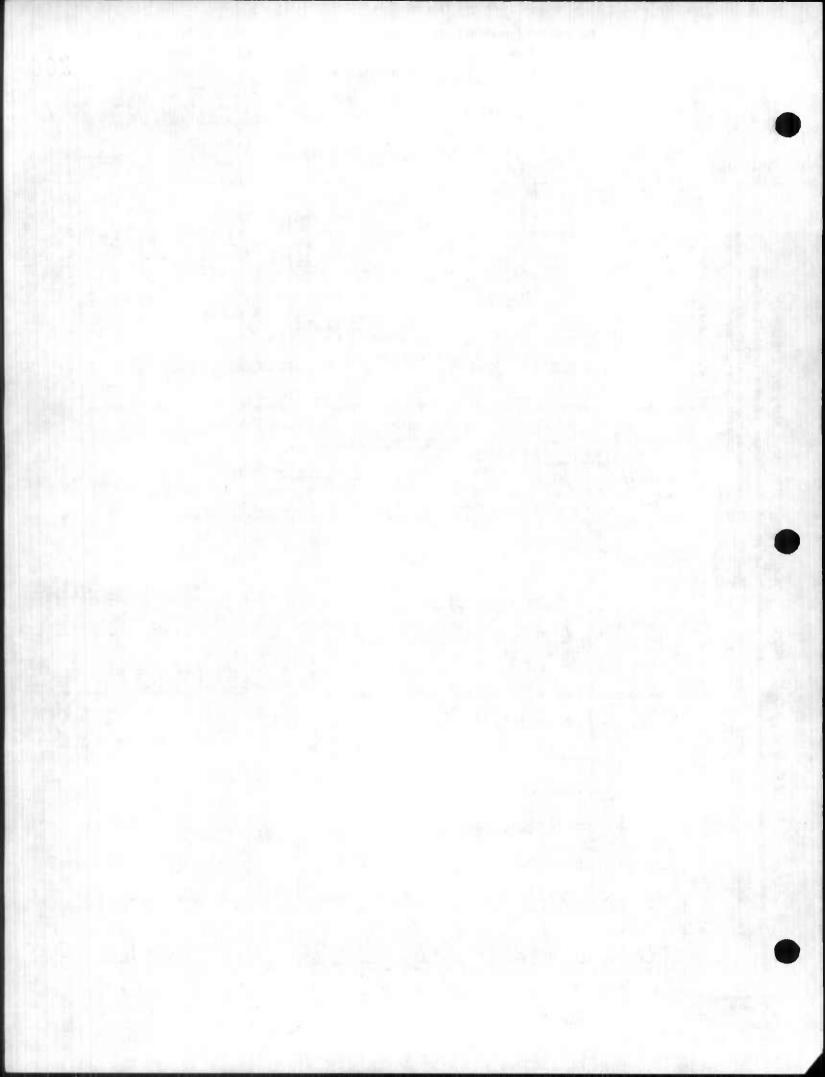
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Fun	neral	5. Social Security		. Sex 1 □ M 2 🔀 F		last birthday)	If Und Months	er 1 Year Deys	If Under 2 Hours	24 Hrs. 8. 1 Min. 8. 1	Date of Birth Month, Day	Year)	Cour	place (State or For	reign
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	Funeral Director	11. Marital Status		Armed F		J,S. 13.	Wes Dec	ecify Cub	an, Mexican	gin? (Specify , Puerto Rica	Yes or No- in, etc.)	Ble	ca - Americ ck, White,		
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2 2 2	Completed	(Spe	15. Decedent'a ecify only highest g	rade completed,)	16a. Dece	kind of w	vork done	oation during most d)	t of working		16b. Kind of B	usiness/in	dustry	
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Division of Vital Records, for Attending Physician: The law requires t after deeth. Director: After this certificate has been signe	by th	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Plac	a of Injury - At h	nome, lerm, str	eet, lecto	ory, office		281.	Location (S City or Tow	treet end Num	ber or Run	al Route Number,	
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State of Maryland / Department of Health and Mental Hygiene

Physician Medical Examiner of the similarion, poly arrived in number of the similarion of the similari		Certificate of Death	Reg. No.	26201							
Reciprose Part Pa		Decedent's Name (First, Middle, Last)		3. Time of Deat							
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	stor.		(Check only one)								
27. Mepner of Death 1 Natural 5 Pending Investigation 5 Accident 3 Suicide 6 Could not be determined 5 Sec. Place of Injury - Al home, ferm, street, factory, office 28. Location (Street and Number or Rural Route Number of Rural Route Number or Rural Route Number o	direction of	Hospital: (/	me 5 Residence 6 Other ((Specify)							
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building, etc. (Specify)	d in the	4 ☐ Homicide building, etc. (Specity)	Only or Town, State)								
29a. Certifier 12-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.	y fills										
29a. Certifier (Check only one)	P Fu	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Me th	29b. Signature and title of certifier 29c. License number	29d. Date signed (A	Month, Day, Year)							
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30 Name and address of passes who have address of facility and the state of the sta	(,	20 Name and address of person who formalised arms of heart (the party of the party)	1 rugust	10,200							
W 30. Name and address of person who completed cause of Geath (Item 23a) (Type, Print)	W.)	Tolk to C. House I was Respired to the Completed cause of death (from 238) (Type, Print)	1 Enclore A	160							
State 31. Date filed (Month, Day, Year) 32. Registrer's Signature		31 Date filed (Month Play Year) 32 Benister's Cincature	JEWI411 H	1							
State 31. Date filed (Month, Day, Year) 32. Hegistrer's Signature AUG 1 8 2000 have by		OI, Date they from Day, 1981/ 32, Peustrel's Sunature									



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. 00-4508-027 AMEND ITEM#23 PARSate of Maryland Poepartment of Health and Mental Hygiene Larry DOVE AMMEND ITEMS: #23 PART I, 27, 28A-F PER MEX GT BOOK P. JVW 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** Larry Ronald Dove AUGUST 11,2000 7:08 P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4s Facility Name (If not institution, give street and number) Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M x2 F Months Days 49Yrs. January 10, 1951 MD **Director** 218-62-2033 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be nothled at 1 ☐ Yes 2 ☐ No Director Maryland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 20794 7615 Washington Blvd Funeral death Nems 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Menitel Stetus Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No X If Yes, Give Yeer or Detes: 8 1 Never Merried 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry i Hygiene. Sunny's Surplus Elementary/Secondary (0-12) College (1-4or 5+) Clerk at the Distribution Center 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be nent of Heelth and Mental Agnes M. Delp Harold Benjamin Dove, Sr. and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth Itam 27 2774 St. Johns Lane Ellicott City, Maryland 21042 Mr. Benny Dove Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Good Shepherd Cemetery 08/16/2000 Ellicott City, Maryland 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Iny Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 MO0535 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ck, or hear failure. List only one cause on each line ETHANOL AND Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) ACUTE NARCOTIC INTOXICATION /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of): The law requires that the deeth certificate be execu 68760 that initiated events resulting in death) Last Due to (or es e consequence of): Box (23b. Did tobacco use contributs to the causs of death? PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. detached 1 Yes 2 No 3 Probably 4 D Unknown 5 ρ Records, 8 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy director, page 2 should certificate has 189 Yes 1 Pes 2□ No 2□ No of Vital ai or Attending Physician: T s efter deeth. ii Diractor: After this certificat 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA Medicai Certification: To 28b. Time of 5 3 028c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death Division 5 Pending Investigation 1 Natural Foundi-00 Found: M 1 Yes 2 No UNKNOWN 2 Accident the 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 76.15 WASHINGTON BLVD #34 JESSUP, MD. 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN MOTEL ROOM in by 4 Homleide To the Hospital within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) 29a. Certifier and menner stated. 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end fitte of certifier O.C.M.EO.C.M.E. AUGUST 12, 2000 Dennes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chute, Dennsk Mpelib Penn Street Baltimore, MT 1120nn Street, Baltimore, Maryland 21201

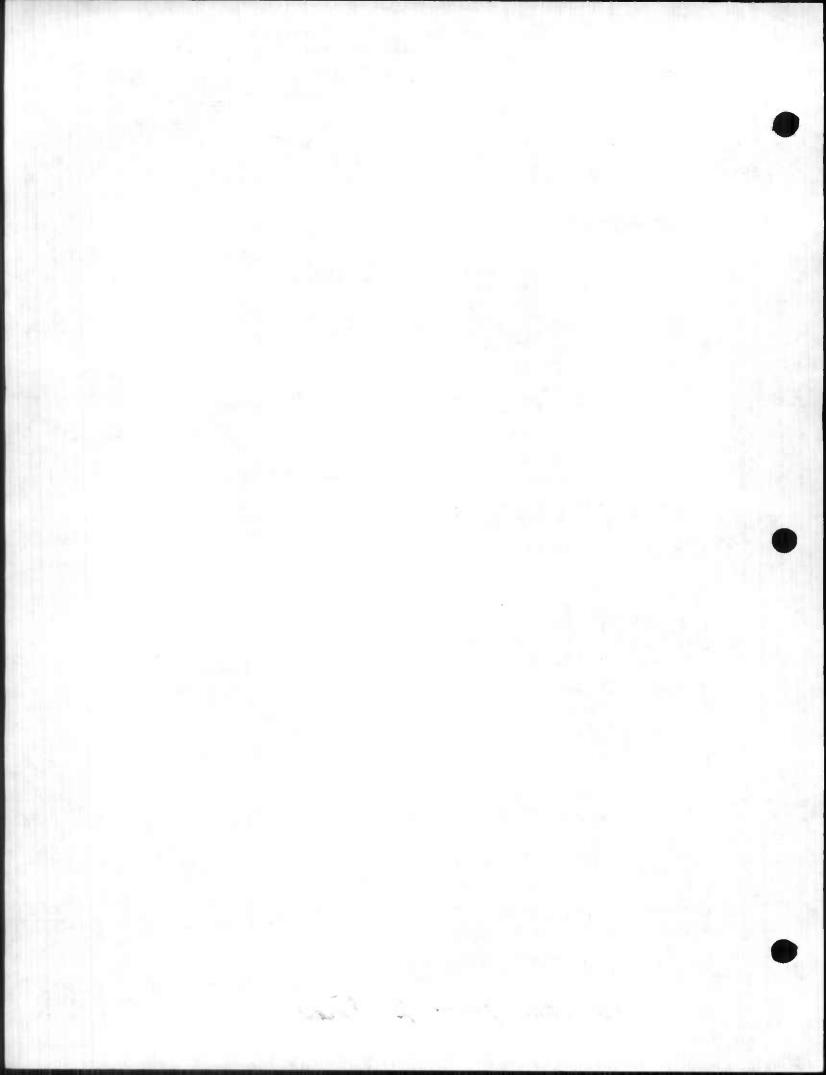
Registrar

State

AUG 18

31. Date filed (Month

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

If Under 1 Year

26202

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Lloyd M. Dutton 2. Dete of Death Month 08-16-2000 3. Time of Death 8:30AM

2813 Parkwood Ave 21217 7. Age (In yrs. last birthday)

4e Facility Name (If not institution, give street and number)

4b. City. Town, or Location of Death Baltimore

4c. County of Death Baltimore City

29d. Date signed (Month, Dey, Year) 8 18/00

Funeral Director If Under 24 Hrs. 8. Dete of Birth Hours Min. JULY 25, 1918

Birthplace (State or Foreign Country)
 MD

MD

ral', or flares 23a or 28a-f show Examiner must be notified at Director Funeral natural, or à Be Completed

filed within 72 hours after permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic avent page.

2

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

Physician /Medical **Examiner**

> Examiner Physician/Medical the p ate hes been signe page 2 should be Completed certificate Be

The law requires that the death certificate be execu To the Hospital or Attending Physician: Within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p edical Certification: To

218-10-5834 187 M 2□ F 82 Yrs Usuel Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 2813 PARKWOOD AVENUE 21217 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried Yes 2 No WWII BLACK 1 ☐ Yes 2 ☐ No Specify: Specify-3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 TELEPHONE CO MECHANIC 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WILLIAM H. DUTTON SIDNEY GASSAWAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2813 PARKWOOD AVENUE BALTO., MD. 21217 BERNICE DUTTON/WIFE 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Suriel 2 Cremetion 3 Removel from State GARRISON FOREST VET. CEM 8/21/2000 OWINGS MILLS, MD. Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 1. Signature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 23a Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final Colon Cancer 1 year diseese or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes ON No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1□ Yes 2□No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Panding Investigation 1 Watural 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide

Registrar

29a, Certifier

Mohamed Al-Ibrahim, M.D. 31. Date filed (Month, Dey, Year)

29b. Signature and title of certifier

AUG 1 8 ZUUU

32. Registrar's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

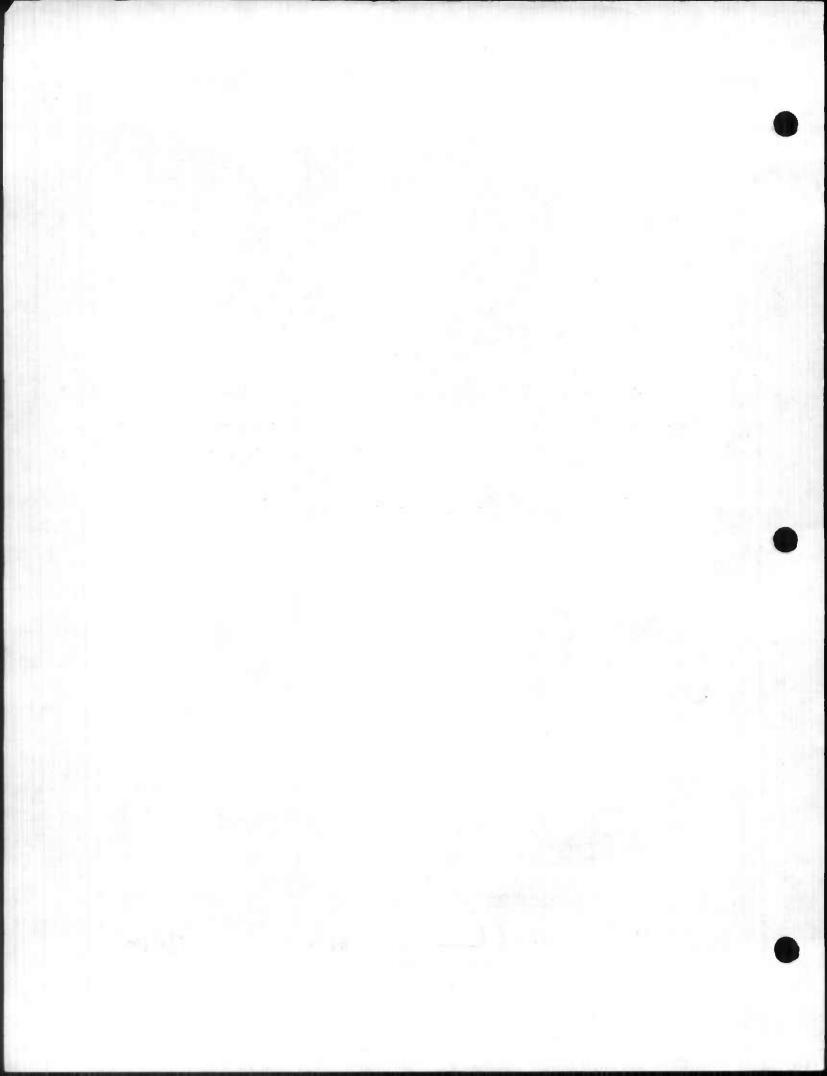
10 N. Greene St. Baltimore, MD 21201

DHMH 16 Rav 6/95

1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated.

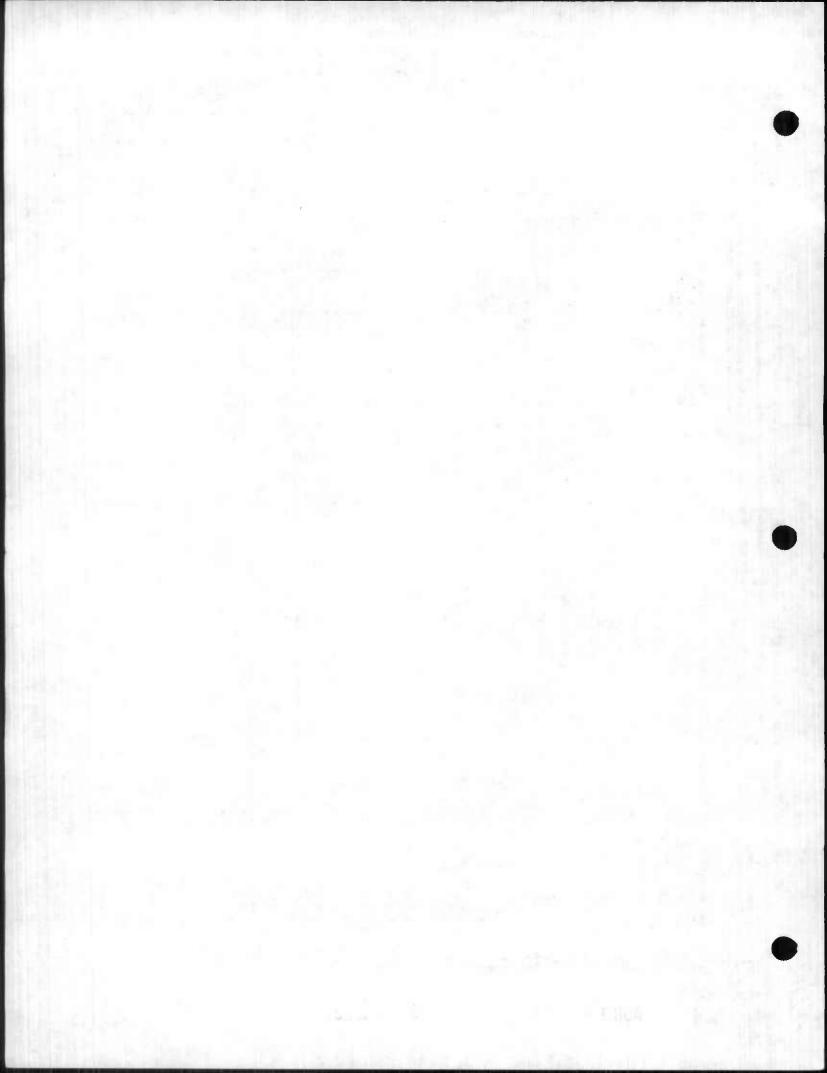
29c. License number



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elizabeth S. Dorsey 1:30 AM Aug, 16 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner 817 E. Quaker Bottom Rd. Sparks Baltimore If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2□ F Yrs. 80 Director 217-12-5789 April 6 1920 Virginia Usual Residence of Decedent the Maryland 10a. Stefe 10b. County 10c. City. Town or Location 10d. Inside City Limits nem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at MD Baltimore 1 ☐ Yes 2 No Sparks Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 817 E. Quaker Bottom Rd. 21152 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: by 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Decement of Health and Mentel Hygiene. Important 1 flem 27 is marked other than "natural", any injury or other treumadic event Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co. Food Handler 6 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Hezikiah Stewart 10 Betty Clark 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 E. Quaker Bottom Rd., Sparks, MD 21152 Howard Dorsey, Jr./Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 8/19/00 4 ☐ Donation 5 ☐ Other (Specify) Stevenson AME Church Cem. Sparks, MD 21. Signatore of Euroral Service 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, Lemmon Part The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examine the attending physician and hed for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): icate be exect Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequenca of): P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yas 2 No 3 Probably 4 Unknown lipo de nia Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s certificate has 1 Yes ZNO 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending P 124 hours after deeth.
 Funeral Director: After t 5 Pending investigation 1 Yes 2 No 2 Accident the 281. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D TE Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier completely 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonard Raucher, M.D. 2205 York Rd. Timonium, MD 21093 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State AUG 1 8 2000 Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Linda 10:40 AM. Elliott AUGUST 16, 2000 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE BALTIMORE If Under 1 Yaar If Under 24 Hre. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Deys Hours 1 M 2 F 212-48-2921 53 Yrs. Md. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2809 Dunglen Ct. 21222 USA 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, epecify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Merital Status 1 ☐ Yes 27 No If Yes, Give 1 Navar Married 2 Merried Specify: Whiite 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Yaar or Datas: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 8 Yrs College (1-4or 5+) Housewife own home 18. Mother's Neme (First, Middle, Maiden Surnama) 17. Fathar's Neme (First, Middle, Last) Elmer Francis Wisner Gladys Ruth Hembree 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Leonard sister 7816 Eddlynch Rd. Dundalk, Md. 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) Aug 17 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Metro Crematory 2000 Catonsville, Md. Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 Inter the disaese, or complications that causad the death. Do not anter tha mode of dying, such es cardiac or respiretory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL INFARCTION disease or condition resulting in deeth) Due to (or as a consequence of): DISEASE ORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Dua to (or as a consequence of) 23b. Did tobacco use contribute to the ceuse of death? 1 Yea 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of causa of death? 2-1 No OBSTRUCTIVE PULMONARY DISEASE 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner Physician/Medical Examin

Physician

/Medical

Examiner

Funera

Director

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Health Hem 27 l

Pages

Maryland 21215-0020

Baltimore,

Box 68760,

P.O.

Division of Vital Records.

Directo

Funeral

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Be Completed

Certification: To

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. CONGESTIVE HEART FAILURE HYPERTENSION CHRONIC 25. Wes case referred to medical examiner? Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, straet, fectory, office building, etc. (Specify) 4 Homicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner stated. 29a. Certifier 29d. Date eigned (Month, Day, Year) 29c. Licanse number 29b. Signature and title of cartile

State Registrar

DHMH 16 Rev 6/95

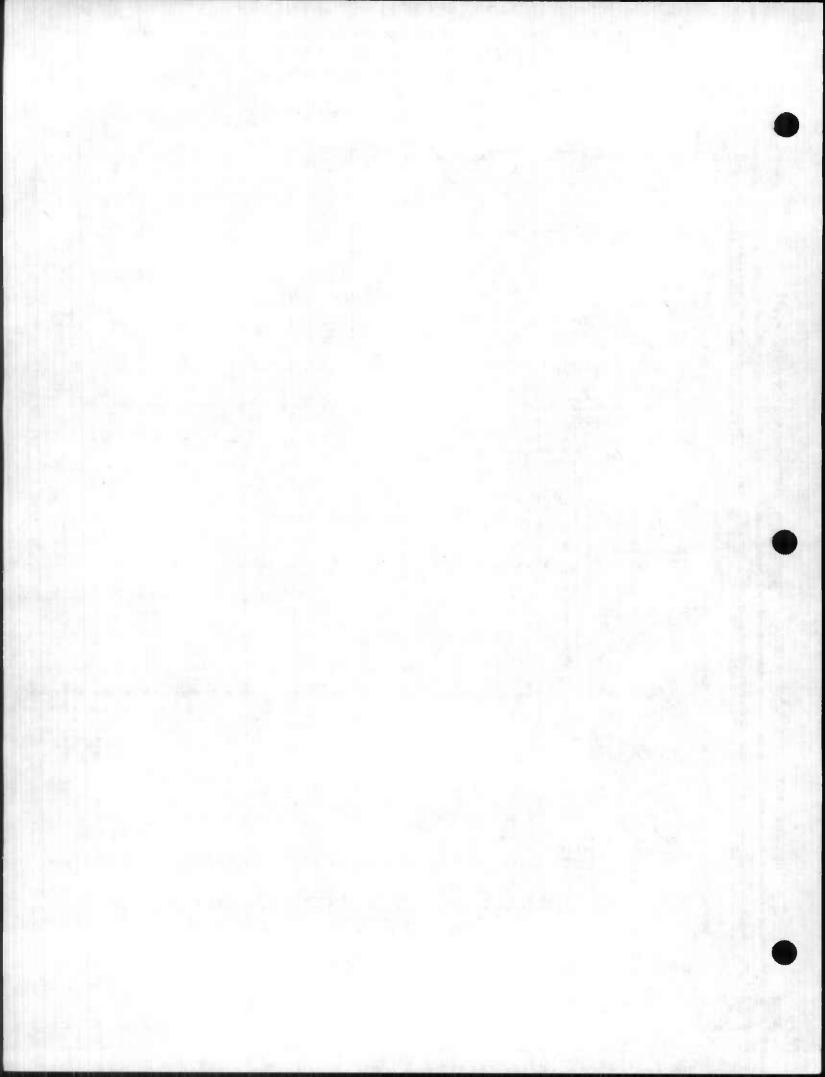
GHAZARIAN, MD. 20032. Registrar's Signafore

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

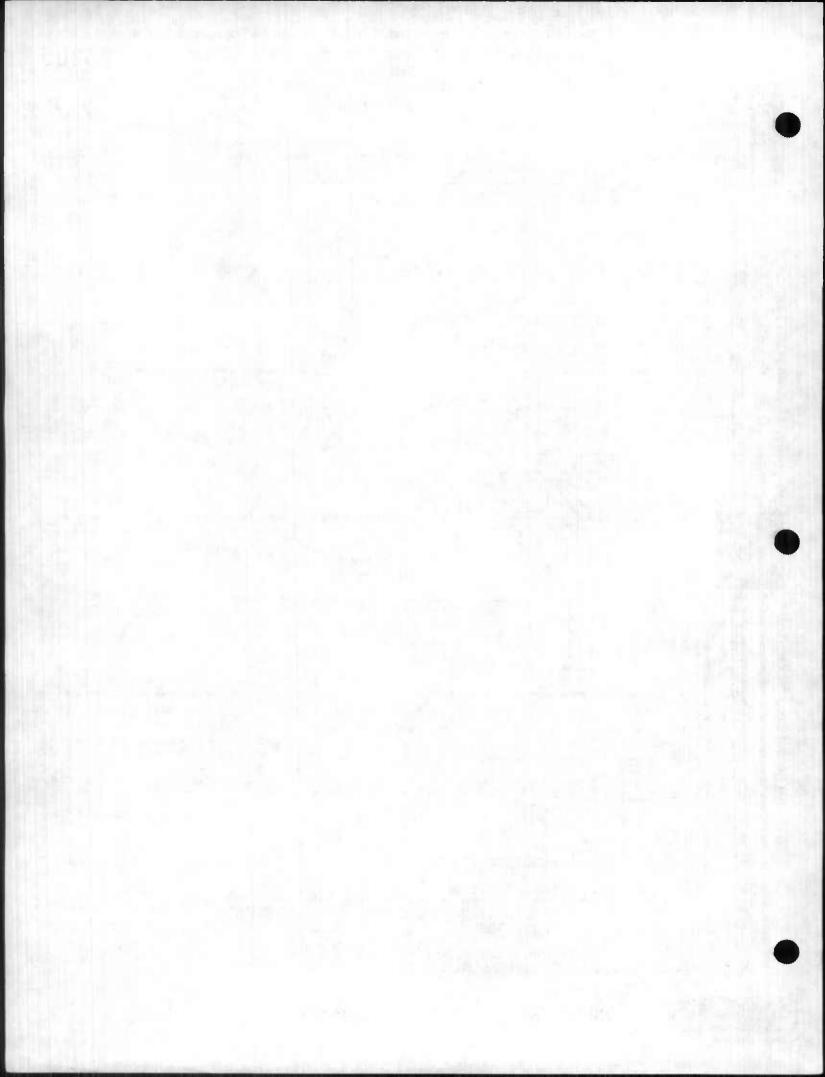
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AUGUST 16, 2000



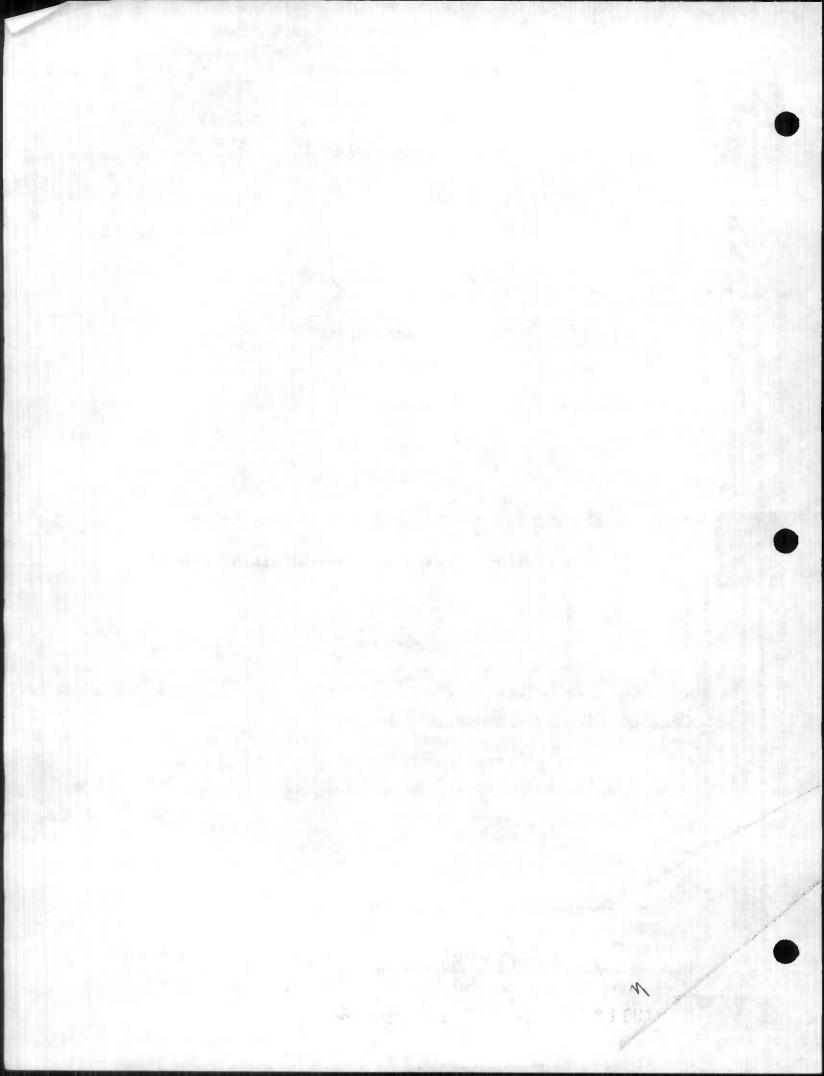
State of Maryland / Department of Health and Mental Hygiene 00 26205

			C	ertificate	of Death		Reg. No.		
	1. Decedent's Name (First, Middle,	Last)				2. Dete of Month	Death Day	Year	3. Time of Death
Physician	JESSIE		£	ERVIN	V	ALLC		2000	17.50 AM
/Medical Examiner	4a Facility Name (If not institution,	give street end number)		4b. City, To	own, or Location of De		of Death	
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Funeral		6. Sex 7. A	ge (fn yrs. last birthde	(y) If Under 1 Y	eer If Under ays Hours	24 Hrs. 8. Date of (Month,	Birth Dey, Year)	9. Birthp	elace (State or Foreign
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the Ma	MD		BALTIMO	JRE					1X Yes 2 No
or 28e-f s be notified Director	10e. Street and Number			10f. Zip Co	de		10g. Citizen of	What Coun	ntry?
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r hems 23s siner must Fumeral	11. Merital Status	12. Wes Deceden Armed Forces	t Ever in U,S. 1:	3. Was Decedent	of Hispenic Ori Cuban, Mexican	igin? (Specify Yes or n, Puerto Rican, etc.)	No- 14. Rac	ce - Americ	
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9 0	17. Father's Name (First, Middle, L.	est)				er's Name (First, Mid		ne)	
To	JOHN ERVIN				1.1.	LLIE MAE	ERVIN		
The second	19a. Informant's Name/Relationshi					er or Rural Route Nu		, State, Zip	Code)
27 agr tr	MICHAEL ERVI	(SON)				BALTO. M	D 21215		
and the	20a. Method of Disposition	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. Place of Dis	sposition (Neme or other	of r place)	Date	20c. Location	- City or To	own, Stete
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	288 Part1 Enter the disease, or o shock, or heart failure. List of	omplications that cause	d the death. Do not	enter the mode of	dying, such es	cerdiac or respiretor	y arrest,		Approximate
hysician	shook, or heart failure. List o	nly one cause an each	line.						Interval Between Onset and Death
Medical	Immediate Ceuse (Final		STAGE	- /,	VER	DISEAS	E	1	
kaminer	disease or condition resulting in death)	a. END			, , ,	D. J. C		1	
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,	18	melin	no	D	302	72	8/15	120	Cor
0	30. Name and address of person w	ho completed cause of	death (Item 23a) (Typ	e, Print)					
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State	31. Date filed (Month, Day, Year)		trar's Signature	4	na V	70.			
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State of Maryland / Department of Health and Mental Hygiene

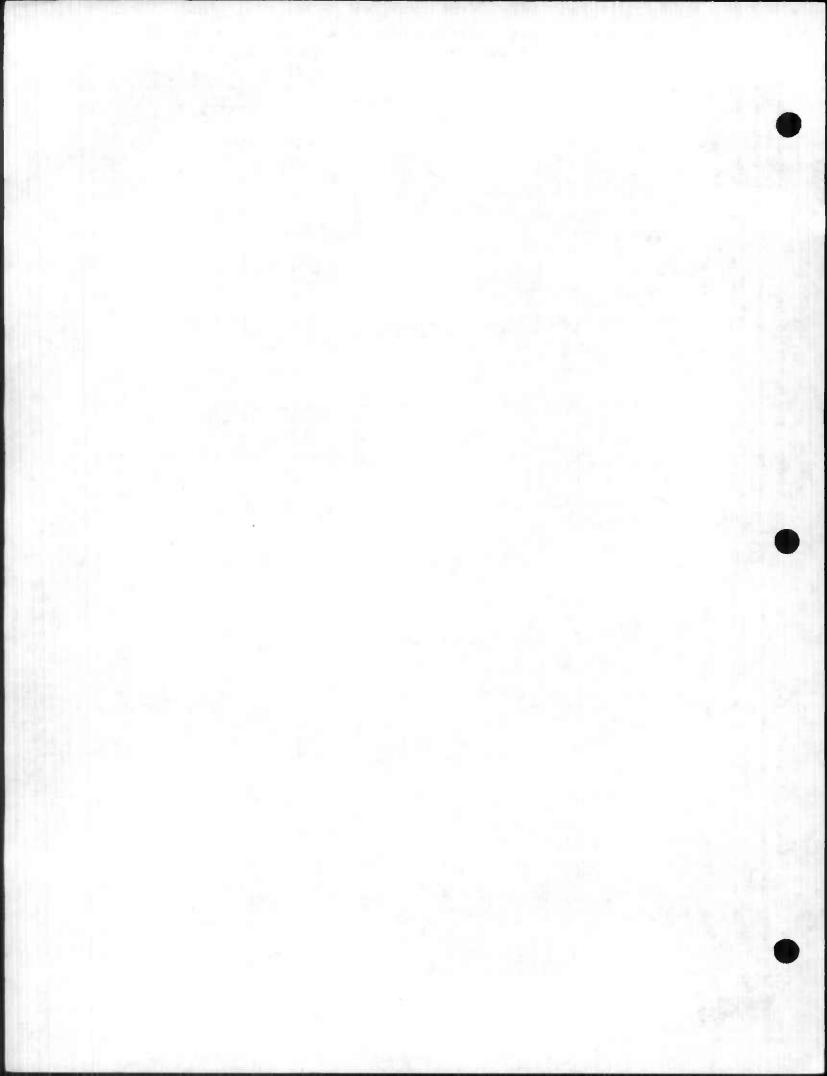
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/Medical	Joan Delores Ellis		08 11	2000 3302				
Examiner	4a Facility Neme (If not institution, give street end number)	4b. City, Town, or Lo		ty of Deeth				
	5. Social Security Number 6. Sex 77. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		O Birthulana (State on Four				
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injury .	4 Donetion 5 Other (Specify) Mt.Zic 21. Signature of Fuperal Service Licenses 22.	Nama end Address of Fecility	8/18/00 Lar	nsdowne Md.				
Department		Chavis Funeral Ho	me, P.A., 200	7-09 Eastern				
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0 8	that initiated events resulting in death) Last d							
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cate has been signed be page 2 should be determined by PI			24a. Was an autopsy performed?	24b. Were autopsy findir available prior to completion of cause of death?				
irector, page 2 s irector, page 2 s			1 Yes 2 No 1 Yes 2 No					
this certific ral director,	25. Wes case referred to medical examiner? Hospital:	Other:	(Check only one)					
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al Director: After to in by the funeral Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, stree building, etc. (Specify)	et, fectory, office	28f. Location (Street end Nur City or Town, Stete)	ocation (Street end Number or Rural Route Number, City or Town, Stete)				
E4 hour Funer stely fill cal	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth 2 Medical Examiner: On the best of examination end/or investigation and manner steted.	estigation, in my opinion, deeth occurr	ed et the time, dete and plece	e, and due to the cause(s)				
within To the comple	29b. Signatura and title of certifier	29c. License number	29d. Date sign	ned (Month, Dey, Year)				
	VII Mil	OCME	8/1	7/00				
3	30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, P MAY G. RIPPLE, M.A. [] (2)	nn Street Bal	timore, md.	21201				
State Registrar	31 Data filed (Month Day West) & Benistra's Signatural	foods						



ysician	4 De	adanta Mar	e (First, Middle, La	eet)		Ce	ertificate	of Death	2. Data of Dea	leg. No.	0 2	5207 3. Tima of Death		
Medical		ESTEL	LE				FISHMA		Month AUGUST	AUGUST 16 , 2000 1				
aminer	4a Fa			ve street and numbe					Location of Death					
	E Cod	48.		SHOP CIRC		last birthday	If Under 1	OWINGS Yaar If Undar 24 Hr.			TIMORE			
eral	03	9-16-9	481	1□ M 2□F		72 Yrs.		Days Hours Mir		, Year)	Country	ce (State or Foreign) T		
H .	10a. S	itete	10b. County		10c. Cit	y, Town or i		_		10d. Inside				
Director	10.6	MD	BALTI	MORE		OWING	S MILL			1 ☐ Yes				
-	100. 8	treet and Nur 481		SHOP CIRC	LE		10f. Zip (21117		-	.S.A.			
iner must		anital Status		12. Was Deceder Armed Forca	\$?	,S. 13	. Was Decede	ent of Hispanic Origin? (fy Cuban, Maxican, Pue	Specify Yes or No- rto Rican, etc.)		e - Amarican ck, White, etc			
by by	31		iad 2 Married 4 Divorced	1 Yas 20 If Yes, GiveX Yaar or Datas	2☐No eXX Itas: 1☐ Yas 2∏I		No Specify:		Specify	WHIT	E.			
r, the Medical		(Spec	15. Decedant's E	ducation ada completed)		16a. Dec	edent's Usual e kind of work	Occupation dona during most of we retired)	orking	16b. Kind of Bu	usiness/Indus	ss/Industry		
dmo	Ele	mentary/Seco	ondary (0-12)	College (1-40	or 5+)	lifa.		ACHER		SPECI	AL EDU	CATION		
17. Father's Nama (First, HARRY 19a. Informent's Name/F AUDRA CAPI	17. Fa	thar's Nama	(First, Middla, Las)					ame (First, Middle,	Meiden Sumem	18)			
	RY		1	WEINST		FAN								
		(Type, Print) DAUGHT	ER	19b. Mai		(Street and Number or F LVIN AVENUE								
		Method of Disp		70		Place of Disp cemetery, cre	osition (Name	e of her placa)	Date	20c. Location -	City or Towr	n, State		
			5 Other (Speci	Removal from Sta	C	HEVRA	AHAVAS	CHESED	8/17/00	RANDAL	LSTOWN	, MD		
200		.12	ineral Service Lice	1 -				Address of Facility	SOL LEVINSON & BROS., INC.					
		Mole	0	f	>	2	900 RE	EISTERSTOWN of dying, such as cerding	ROAD - P	IKESVIL	LE, MI	21208		
	238.	shock, or hea	na disaase, or con int failure. List only	one cause on aach	sed the deat n line.	n. Do not e	nter the mode	or dying, such as cerdi	ac or respiratory an	rest,	Î	pproximete nterval Between Inset and Death		
in al	Imme	Immediata Cause (Final disease or condition										10010		
r .	result	ing in deeth)	or condition a. Due to (or as a consequence of):					AA IV V		14	- July			
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		entially list co , leading to in . Enter Unde	anditions, amediate	b. ————		or as a conse		0. 1						
Ca Ca	Ceus that in	entially list co leading to in to inter Unde (Disease or litiated events ing in death) l	injury	b	Due to (d		equence of):	0. (
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Be Completed by Physician/Medical	Ceus that ir result Part II	e (Lisease or entitle)	Injury S Last		Due to (d	or as a conse	equence of):	26. Place of D	1 1 1	an autopsymed?	3 Proba	a autopsy findings able prior to olation of causa ath?		
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pieted by Physician/Medical	Part III 25. Web 11 27. M. 29 34	as cese refaraminer? Yes Anner of Deat Natural Accident Suicide Homlcide Certifier	Ilcant conditions of the condi	Hospital: 1 ☐ Inpe 28a. Dete of Ir (Month, I) 28e. Plece of building,	Due to (of	er as a consecuting in the ER/Outpatic Injury	equence of): underlying ce ent 3 DO/ of 28 M etreet, factory.	26. Place of Di A Other: 4 Nursing 3c. Injury et Work? 1 Yes 2 No	24a. Was perior 24a. Was perior 1 Veath (Check only of the check	an autopsymed? (as 2) No ne) lence 6 □Oth ow injury occur Street and Number, State)	3 Probei 24b. Wers avails comp of de 1 1 v ner (Specify) red	bly 4 ☐ Unknow a autopsy findings able prior to olation of causa ath? Yas 2 (À No		
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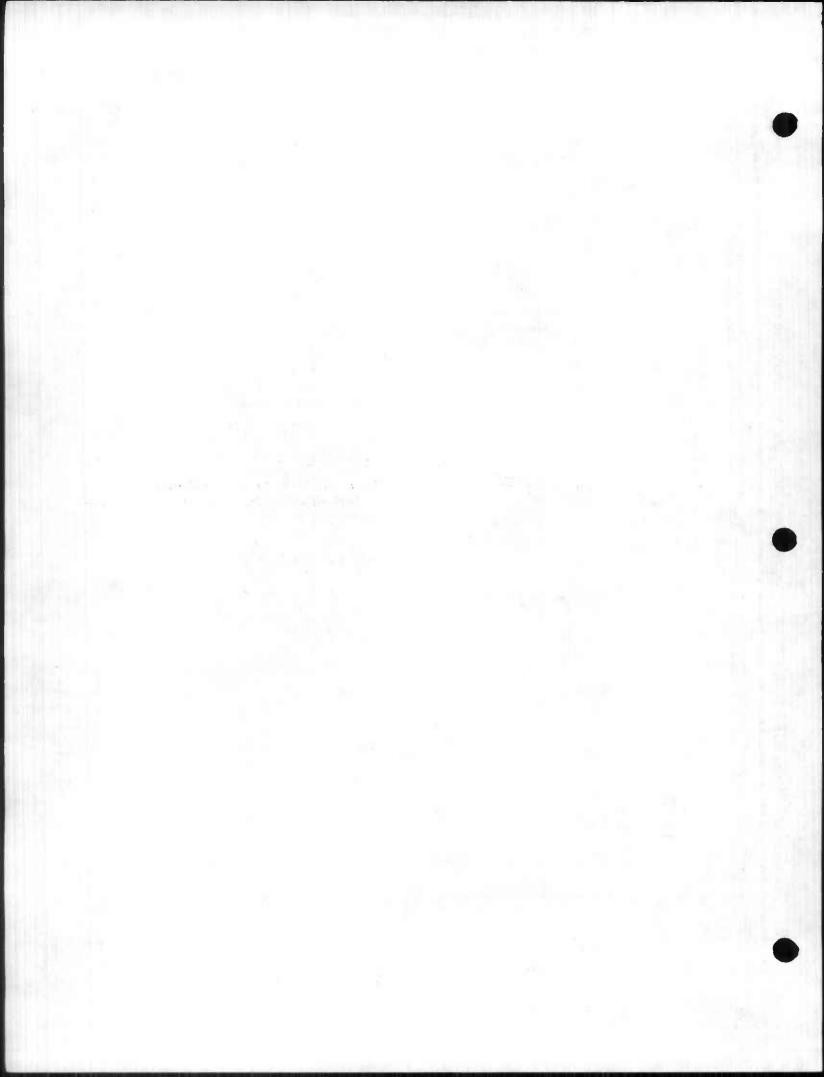
State of Maryland / Department of Health and Mental Hygiene 00 26208

	Certificate of	Death		Reg. No.						
	1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day Year									
sician	ALEXANDER PERNANDEZ		AUGUS		7,000 4:4					
ledical aminer	ia Facility Neme (If not institution, give street and number)	4b. City, Town, or L			ty of Deeth					
	Northwest Hospital Center	Dandalla	at orm	Balt	timore					
eral	i. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yee		8. Dete of B							
tor	233-28-5077 1Ã M 2□ F 78 Yrs. Months Deys	nours Min.	Sept.	irth 8, 1921	9. Birthplace (State of Country) Rome, New					
	Jsuel Residence of Decedent		tod bolds Ob. H							
uneral Director	10a. State 10b. County 10c. City, Town or Location				10d. Inside Cit					
oto	Maryland Baltimore Pikesville				1 □ Yes					
Directo	IOe. Street and Number 10f. Zip Code		10g. Citizen of What Country?							
8	4515 Tapscott Road 21208	3		U.S.A.						
Funeral	11. Maritel Stetus 12. Wes Decedent Ever In U.S. Amed Forces? 13. Wes Decedent of It Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or N o Rican, etc.)		ace - American tndian, ack, White, etc.					
E.	1 ☐ Never Married 2 ☑ Merried 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No									
d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII		70.00	Орост	y Spaniard					
Completed	15. Decedent's Education 16a. Decedent's Usuel Occu (Specify only highest grade completed) (Give kind of work done	e during most of world	king	16b. Kind of I	Business/Industry					
di.	Elementery/Secondary (0-12) College (1-4or 5+)									
00	4 Industrial Er	0		Westing						
8	17. Father's Neme (First, Middle, Last)	18. Mother's Nam			ime)					
0	Manuel Fernandez	Francis	sca Borl	oolla						
- 0	19e. tnforment's Neme/Reletionship (Type, Print) 19b. Malling Address (Street									
	Carmen Fernandez (Wife) 4515 Tapscot	t Koad, P	rikesvi.	ile, Mar	cyland 21208					
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other pl.	ace)	Dete	20c. Location	- City or Town, State					
	1 Donation 5 Other (Specify) Arlington National	1	3/24/00	Arlingt	on, Virgini					
	21. Signature of Fundral Sary to Licensee 22. Name and Addi	ress of FecilityLor	ing By	ers Fune	ral Directo					
g	8728 Liber									
	234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy hood, or heart failure. List only one cause on each line.	ving such as cardiac	or respiratory	errest	Approximete					
Medical Examiner	b. Due to (or es e consequenca of): fi eny, leading to immediate cause. Enter Undertying Ceuse (Disease or injury that initiated events resulting in death) Last b. Due to (or es e consequenca of): Due to (or es e consequence of):	uis Co								
Physician	d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I.		d tobacco use c	contribute to the cause of					
by P	July Hallo of			3100 20110						
	Selle pleasa 500		24e. We	s an eutopsy formed?	24b. Were autopsy f					
Completed	propries		per	ionnog r	completion of c					
Junc			10	Yes 2 No	1 Yes 2					
O O	25. Wee case reterred to modical	ne blass 45			10.192 20					
o Be	25. Was case reterred to medical examiner? Hospital: Hospital: 10 PAR 0	26. Place of Dea			thes (Case-Ma)					
-	1 Empatient 2 ER/Outpatient 3 DOA	4 Li Nursing H		sidenca 6 0 how injury occi						
Certification:	1 Naturel 5 Pending (Month, Dey Year) Injury W	ork? □ Yes 2 □ No		127 030	Part of					
Ica	3 Suicide 6 Could not be an at lating At home for shoot factors office		28f. Location	(Street and Nun	nber or Rural Route Num					
T.	4 Homicide determined building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, Stete)							
	20e Cortilior 1 Cortificing Dh. Italian Talka host of	time date and stars	and due to the	a coursels) and	mennor ac stated					
edical	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of axeminetion end/or investigation, in my and manner stated.									
Med	The first field of the state of	nse number		29d Date sign	ned (Month, Day, Year)					
-	29b. Signeture end title ot ce/titier 29c. Licer	1/16								
	1018	44503		11464	187 14,2					
	30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) AS IMPERIO, Tr. Will	^	JWH	C,						
tate	21 Date filed (Month DW Veer) 22 Decistrate Signature									
State strar	AUG 1 8 2000 Beneva & Soo	121								
	AUG 10 / UUU AAAA									

State of Maryland / Department of Health and Mental Hygiene 26209. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:45 a.m. August 14 2000 Thomas Galvin Foster, Sr. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Spa Creek Annapolis Anne Arundel 8. Dete of Birth (Month, Day, Ye July 2, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 218-16-2273 77 Yrs 1923 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Annapolis Director 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 926 Boom Way 21401 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiens. Important if them 37 is marked other as any Injury or other transfer other as 2006. 14. Raca - American Indian, Black, White, etc. **Herna** 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White by 3 ₩ Widowed 4 Divorced Year or Dates: WWTT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Air Force Pilot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George Ivanhoe Foster Mary Matilda Adams 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas G. Foster, Jr./son 926 Boom Way Annapolis, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 DOther (Specify) Arlington National Cemet. 8/28/00 Washington, D. C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd., Baltimore, Maryland shock, or heert tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cardio my exally Cu disease or condition resulting in deeth) Examiner Auterior look a vardar Lieu Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of) for use as the burial-trai P.O. Box 68760, Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? defached cate has been signed by page 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown Records, þ Be Completed 24b. Were autopsy tindings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital director, 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Rursing Home 5 Residence 8 Other (Specify) edical Certification: To 1 Yes 2€No epital or Attending Physical Physical Director: After this peral Director: After this y filled in by the funeral di 27. Manner of Deatl 28e. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation T- Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it table Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signeture and title of certifin 29c. License number 29d. Date signed (Month, Day, Year) 32036 000C/VI/8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dive Clayter, MD 21619 2/11 p. Durah 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State ports AUG 1 8 2000 Registrar

ORIGINAL.



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 1. Decedent's Nama (First, Middle, Last) Month Rosetta Gill 12:07 am August 2000 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Johns Hopkins Bayview Medical Center Baltimore Baltimore City 7. Age (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. Birthpleca (State or Foreign Country) 5. Social Security Number 6. Sex Months Days Hours 1□M 2X F Yrs 217-30-5054 6/22/35 Md. Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County NA Baltimore Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 1309 E. Eager St. IJS A 14. Haca - American Indien, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerio Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yes 為☐No If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Detes: 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Human Resource

22. Nama end Address of Facility

March F.H. East

20b. Pleca of Disposition (Name of cametery, crematory or other placa)

Failure

Failed Renal Transplant

Due to (or es a consequenca of):

Cedar Hill Cem.

Director or flams 23a or 28a-f the Medical Examiner must be notifi-Baltimore, Maryland 21215-0020 Completed Pages 1 and 2 should be if Nem 27 is marked o

Physician

/Medical

Examiner

10e. Stete

Funeral

Md.

Elementery/Secondery (0-12)

17. Fathar's Nema (First, Middla, Last)

Odell O. Goodmin

19a. Informent's Name/Reletionship (Type, Print)

ladys

Funeral

Director

Physician /Medical Examiner

The law requires that the death certificete be execut

been signed by

this certificate has

P.O. Box 68760,

of Vital Records,

Division

Physician/Medical Examiner by 8 Be Completed al or Attending Physician: The safer death.

I Director: After this certificated in by the funeral director, page to the funeral director director, page to the funeral director direct

Leroy Gill 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. 1 Yes 2 No Certification: To 27. Manner of Death 1 ☑Neturel 2 Accident 3 Suicide 4 Homicide Medical 29a. Certifler (Check only one) 29b. Signeture end title of certifier

To the Hospital or Attention 24 hours after der To the Funeral Diracto completely filled in by th State Registrar

Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immadiata cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Brain Injury Enterocutaneous Fistula 25. Was case referred to medical exeminer?

Hospitel: 12 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of 5 Pending investigation 8 Could not be determined

College (1-4or 5+)

Dane

Renal

Diabetes Mellitus

28e. Pleca of tnjury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number 21015

28c. Injury at Work?

1 Yaa 2 No

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and placa, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Day, Year) August 16,2000

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

State Office Blq

20c. Location - City or Town, Stata

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yss 2 ☐ No

1 Yes 2 No

28d. Describe how Injury occurred

24a. Wes en eutopsy performed?

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

26. Place of Deeth (Check only one)

21202

Approximate Interval Between Onset and Death

7 years

lo years

3 Probably 4 ☐ Unknown

24b. Were eutopsy findings available prior to completion of causa of death?

1 ☐ Yas 2 ☐ No

8/23/00 Anne Arundel Co.,

Baltimore, Md.

1101 E. North Ave.

Williams

18. Mother's Name (First, Middle, Maiden Sumame)

Date

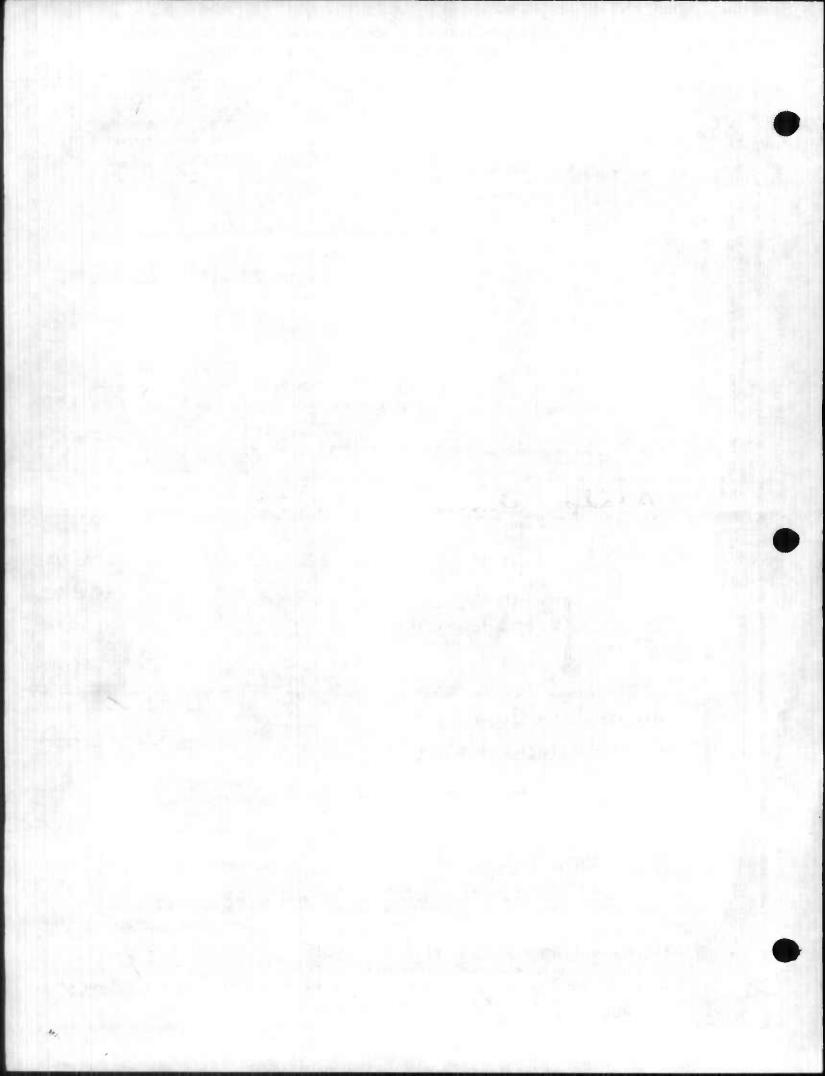
Christine

19b. Meiling Address (Street end Numbar or Rural Route Number, City or Town, State, Zip Code) 1309 E. Eager St., Baltimore, Md.

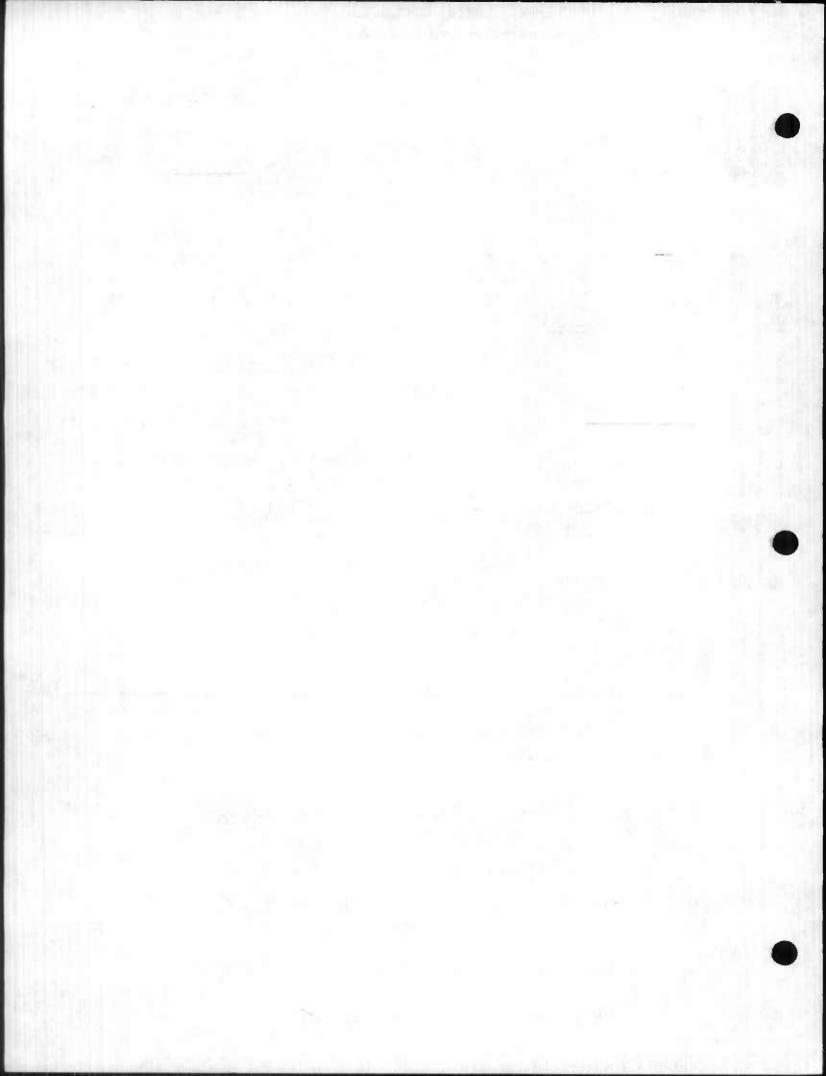
Mbela folloman, resident physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rebecca Gottesman, Johns Hopkins Bayriew Medical Center, 4940 Eastern Avenue, Bultmore, Maryland

32. Registrer's Signature



AMEND#8,10E,1	First, Middle, Last,)					2.	Date of Dea Month	12 ^{Day} 2000	Year	3. Time of Death
FANNIE			GURE	VITCH		4b. City, Town	AU				4:15PM
4a Facility Name (If no						BALTIM		or or beauti	4c. County BALTI		
5. Social Security Num	ber 6. Se	x 7. Age	e (In yrs. last bi	Month	ler 1 Year s Days	If Under 24	Hrs. 8.	(Month, Day	h 3/7/1915	9. Birthp	lace (State or Foreign
220-36-167		□M 2 X F	85	Yrs.		1.00.0	M	AR 17	1915	MD	,
Usual Residence of De 10a. State 10	ob. County		10c. City, Tow	Town or Location					10d. Inside City Limits		
MD B	ALTIMORE		BALT	IMORE						100	1 ☐ Yes 2 ☐ No
10e. Street and Number	er .			10f. Z	Zip Code				10g. Citizen of V	What Coun	itry?
7 SI	LADE AVE	. APT. 30						U.S.A.			
	Ital Status Never Married 2 Married Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:			If Yes, sp	pecify Cub	tispanic Origin an, Mexican, F Specity:	n? (Specify Puerto Rica	/ Yes or No- an, etc.)	Blac	a - Americ ck, White,	etc.
	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of					16b. Kind of Bu	usiness/ind	dustry
Etementary/Seconda	entary/Secondary (0-12) College (1-4or 5+)			life. DO NOT	use retire	d)					Uraniti
12 17. Father's Name (Fir	st. Middle, Last)		RE	AL ESTA	TE AC		Name (F)	irst. Middle.	REAL Maiden Sumam		IVE
ISAAC			NAD	NADICH LENA						IATHAI	NSON
19a. Informant's Name					ss (Street		or Rural R	oute Numbe	er, City or Town,		
LEB SACKS/	SON LEE	SACHS/SON	Special Control of the Control of th			RUN CC	URT (OWINGS	MILLS,		
20a. Method of Dispos		Removal from State	cemete	of Disposition (N ary, crematory or	r other pla			Date /OO	20c. Location -		
4 Donation 5			BETH T	FILOH C			8/.	14/00	WOODLA	IMN , MI	D.
21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. INC.											
1/1		1									
23a. Part1. Enter the shock, or heart fall fall fall fall fall fall fall fal	ailure. List only o	ne cause on each lin	io bu		ode of dyin	PERSTON ng, such as ca	N RO	AD PIR	(ESVILLE rest,		
shock, or heart formediate Cause (Finsease or condition sulting in death) equentially list conditionary, leading to immediate. Elisease or injust initiated events	alture. List only of the state	a. Card b. One c. Ny	Due to (or as a	not enter the m	ode of dying of the ode of the ode of dying of dying of dying of the ode of dying of dyin	PERSTON ng, such as ca	N RO	AD PIR	(ESVILLE rest,		21208 Approximate tritervat Between
shock, or heart for indicate Cause (Fin disease or condition resulting in death) Sequentiatly list condition in mecause. Enter Underly) Cause (Disease or injuntat initiated events resulting in death) Las	tilons, adiate ing	a. Card	Due to (or as a	consequence of	Ode of dyli	PERSTON ng, such as ca	N RO	AD PIK spiratory ar	KESVILLE rest.	E, MD	21,208 Approximate Intervat Between Onset and Death
shock, or heart far indisease or condition resulting in death) Sequentially list condition if any, leading to imme cause. Enter Underly Cause (Disease or injulat initiated events resulting in death) Las	tilons, adiate ing	a. Card	Due to (or as a	consequence of	Ode of dyli	PERSTON ng, such as ca	N RO	AD PIK aspiratory ar 23b. Did t	KESVILLE rest.	E, MD.	21208 Approximate tritervat Between
shock, or heart far Immediate Cause (Fin disease or condition resulting in death) Sequentiatly list condit if any, leading to imme cause. Enter Underly Cause (Disease or inju- that initiated events resulting in death) Las	tilons, adiate ing	a. Card	Due to (or as a	consequence of	Ode of dyli	PERSTON ng, such as ca	N RO	23b. Did t	RESVILLE Trest, Robacco use co	entribute to	21208 Approximate tritervat Between Onset and Death
shock, or heart far Immediate Cause (Fin disease or condition resulting in death) Sequentiatly list condit if any, leading to imme cause. Enter Underly Cause (Disease or inju- that initiated events resulting in death) Las	tilons, adiate ing	a. Card	Due to (or as a	consequence of	Ode of dyli	PERSTON ng, such as ca	N RO	23b. Did t	tobacco use co	ontribute to 3 Proi	Date autopsy findings allable prior to mpletion of cause
shock, or heart fa Immediate Cause (Fin disease or condition resulting in death) Sequentiatly list condit if any, leading to imme cause. Enter Underly) Cause (Disease or injuited initiated events resulting in death) Las	atluns, ediate and conditions con	a. Card b. One c. Hype d	Due to (or as a	consequence of	ode of dyli	ven in Part I.	N ROLL	23b. Did t	tobacco use co Yes 2 No	ontribute to 3 Proi	D the cause of death? bebly 4 □ Unknown allable prior to impletion of cause death?
shock, or heart fa Immediate Cause (Fin disease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or in)t that initiated events resulting in death) Las Part II. Other eignifica	tions, adiate and	a. Canda b. One c. Hospital: 1 Inpatie	Due to (or as a Due to (or as a Due to (or as a Due to 2 Deep or a De	consequence of consequence of the underlying	OM (Miles)	ven in Part I.	N ROLL TO THE PROPERTY OF THE	23b. Did to the ck only of the ck only only only only only only only only	Robacco use con Yes 2 No an autopsy rmed?	entribute to 3 Proi	Approximate triterval Between Onset and Death o the cause of death? bebly 4 Unknown ere autopsy findings allable prior to mpletion of cause death? Yes 2 No
shock, or heart fa Immediate Cause (Fin disease or condition resulting in death) Sequentially list conditif any, leading to imme cause. Enter Underlyi Cause (Disease or in)that initiated events resulting in death) Las Part II. Other significa	tilons, adiate ing uny it	a. Canda b. One c. Hospital	Due to (or as a Due to (or a) Due to (or a	consequence of consequence of consequence of the underlying in the underlying utpatient 3 Time of Injury	ode of dyling of the control of the	yen in Part I.	f Death (Cing Home 28d	23b. Did to the ck only of the ck only only only only only only only only	Robacco use conves 2 No one)	entribute to 3 Proi	Approximate triterval Between Onset and Death o the cause of death? bebly 4 Unknown ere autopsy findings allable prior to mpletion of cause death? Yes 2 No
shock, or heart fa Immediate Cause (Fin disease or condition resulting in death) Sequentially list condit if any, leading to imme cause. Enter Underlyi cause (Disease or in)t that initiated events resulting in death) Las Part II. Other eignificat 25. Was case referred examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident	atture. List only or nat thous, ediate and uny st	a. Cando b. One c. Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	Due to (or as a Due to (or a) Due to (or	consequence of consequence of the underlying in the underlying utpatient 3 1	ODOA Offi	ven in Part I.	M ROAT PROPERTY OF THE PROPERT	23b. Did t 1 24a. Was perfo	Robacco use con Yes 2 No one) dence 6 Oth how Injury occur	ntribute to 3 Proi	Approximate triterval Between Onset and Death o the cause of death? bebly 4 Unknown ere autopsy findings allable prior to mpletion of cause death? Yes 2 No
shock, or heart far Immediate Cause (Fin disease or condition resulting in death) Sequentially list condition and the condition resulting in death) Sequentially list condition and the condition of the condition and the conditi	atture. List only or last tlons, ediate and last tlons, ediate and last to medical to me	b. And the best of the best of the cause on each line. a. And the cause on each line. b. And the cause of line and the cause of line. 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. stclan: To the best of the cause of the caus	Due to (or as a Due to (or a))))))))))))	consequence of consequence of consequence of the underlying in the underlying the underlying Marm, street, factore, death occurred	DOA Office or of the first or or office of at the first order.	ven in Part I. 26. Place of the rick? Yes 2 No.	M ROD rrdiac or re f Death (C) ing Home 28d 28f.	23b. Did t 1 24a. Was perfo 1 Describe to City or Town	rest. Robacco use con Yes 2 No one) dence 6 Oth how injury occur Street and Number No. State) cause(s) and managements.	nntribute to 3 Proi	a 21 208 Approximate Intervat Between Onset and Death o the cause of death? bebly 4 Unknown ere autopsy findings ailable prior to impletion of cause death? Yes 2 No
shock, or heart far Immediate Cause (Fin disease or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting to immediate. Enter Underlyi Cause (Disease or injustrational indicated events resulting in death) Las Part II. Other signification resulting in death) Part II. Other signification resulting in death) 25. Was case referred examiner? 1 Yes No 27. Manner of Death 1 (Matural 2) Accident 3 Sulcide 4 Homicide	titions, ediate ing ury it it it is medical investigation	a. Cando b. Cando c. Hospital: 1 Inpatie 28a. Date of Injur (Month, Day 28e. Place of Injur (strength of the building, etc.)	Due to (or as a Due to (or a))))))))))))	consequence of consequence of consequence of consequence of the consequence of co	DOA Office or of the first or or office of at the first order.	ren in Part I. 26. Place of them at the point of the poi	M ROD rrdiac or re f Death (C) ing Home 28d 28f.	23b. Did to the cat the time, of	rest. Robacco use con Yes 2 No one) dence 6 Oth how injury occur Street and Number No. State) cause(s) and managements.	matribute to 3 Proi	Approximate Interval Between Onset and Death Death Onset and D
shock, or heart for the state of the state o	titions, ediate ing ury it it it is medical investigation	b. And the best of the best of the cause on each line. a. And the cause on each line. b. And the cause of line and the cause of line. 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. stclan: To the best of the cause of the caus	Due to (or as a Due to (or a))))))))))))	consequence of consequence of consequence of consequence of the consequence of co	DOA Other Door, office	ren in Part I. 26. Place of them at the point of the poi	M ROD rrdiac or re f Death (C) ing Home 28d 28f.	23b. Did to the cat the time, of	tobacco use converse and autopsymmed? Yes 2 No one) dence 6 Oth how injury occur Street and Number of the converse of the c	matribute to 3 Proi	Approximate Interval Between Onset and Death Death Onset and D



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#20B PER F.H. G786 8-18-2000 JAB Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** BADY 29 0445 GudibANde June GILL 2000 /Medical 4e Fecility Neme (If not Institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Rockville, Mary and
If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) 5. Sociel Security Number 9. Birtholace (State or Foreign Grove Adventist 105 7. Age (In yrs. last kirthday) If Under **Funeral** Days 1 M 2 F Months Director NONE 28, 2000 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or frame 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits 175 Yes 2 No GAithersburg 101. Zip Code Director MONTgomery 10e. Street and Number 10g. Citizen of What Country? Cherrywood 20878 USA Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Bleck, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 DXNo ASIAN 1 Yes 2 No Specify: altimore, Maryland 21215-0020 If Yes, Give Yeer or Dates: A 3 Widowed 4 Divorced INDIAN Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oyes 1 and 2 should be filed within not Health and Mentel Hygiene.
It from 27 is marked other than and or other traumette. Elementery/Secondery (0-12) College (1-4or 5+) INFANT INFANT 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Peges 1 and 2 should be nent of Health end Mentel R. GudibANde DATYA RAdha SeshADRI 19a. Informarit's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RAdha GudibANde Cherrywood Terrace Gaithersburg Md, 20878 mother 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donation 5 Other (Specify) 7/31/2000 Rockville GROVE Adventist hady 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 9901 Med. Crtz. DR. Shady md 20850 Grove Adventist Rockville 23a. Pert1. Enter the disease, or complication shock, or heart failure. List only one cay et cause: on each line beath. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximate Intervat Between Onset and Deeth **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last and Due to (or es e consequence of): P.O. Box 68760. Physician/Medicai Due to (or es a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 5 1 Yea 2 No 3 Probably 4 Unknown 2 been signed les Division of Vital Records. p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 2 1000 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Dinpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Di Natural 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation the Hospital or Attending 1 Yes 2 No deeth. 2 Accident after deeth 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier 29b. Signeture and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

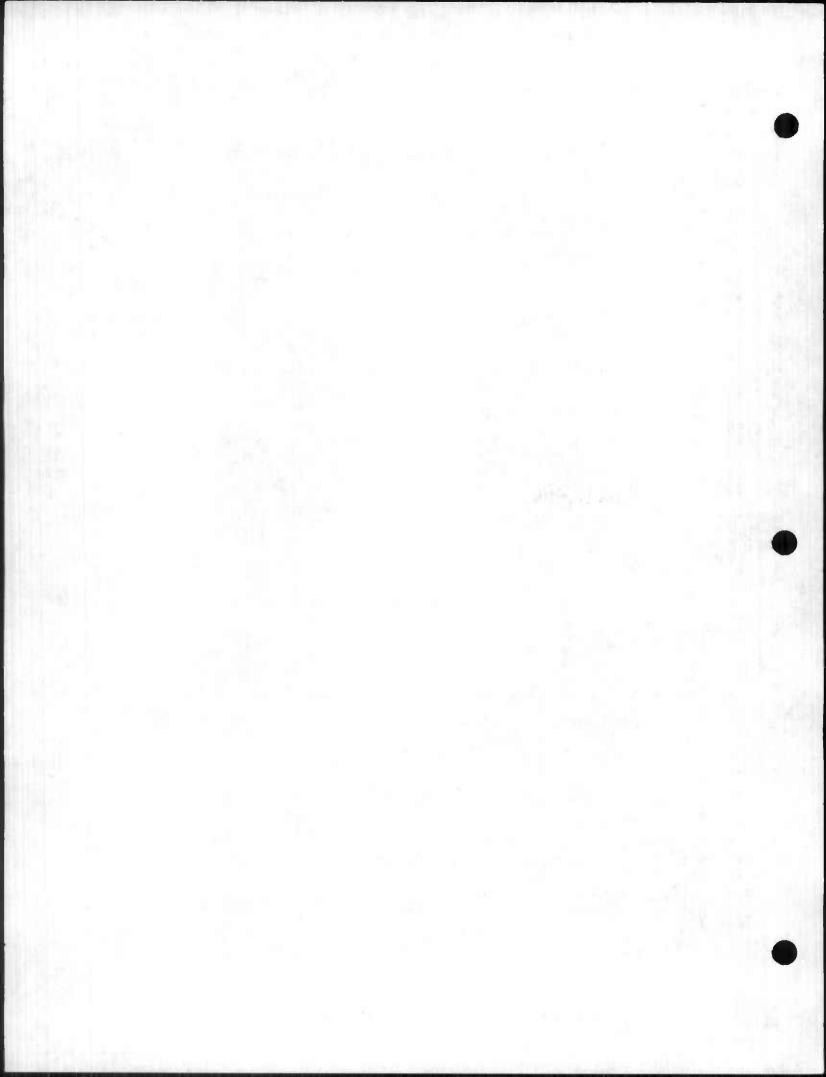
State Registrar 31. Date filed (Month, Dey, Year) AUG 1 8 2000

N. Frederick Ave, Gaithersburg, MD 32. Registrer's Signature

of person who completed cause of death (Item 23a) (Type, Print)

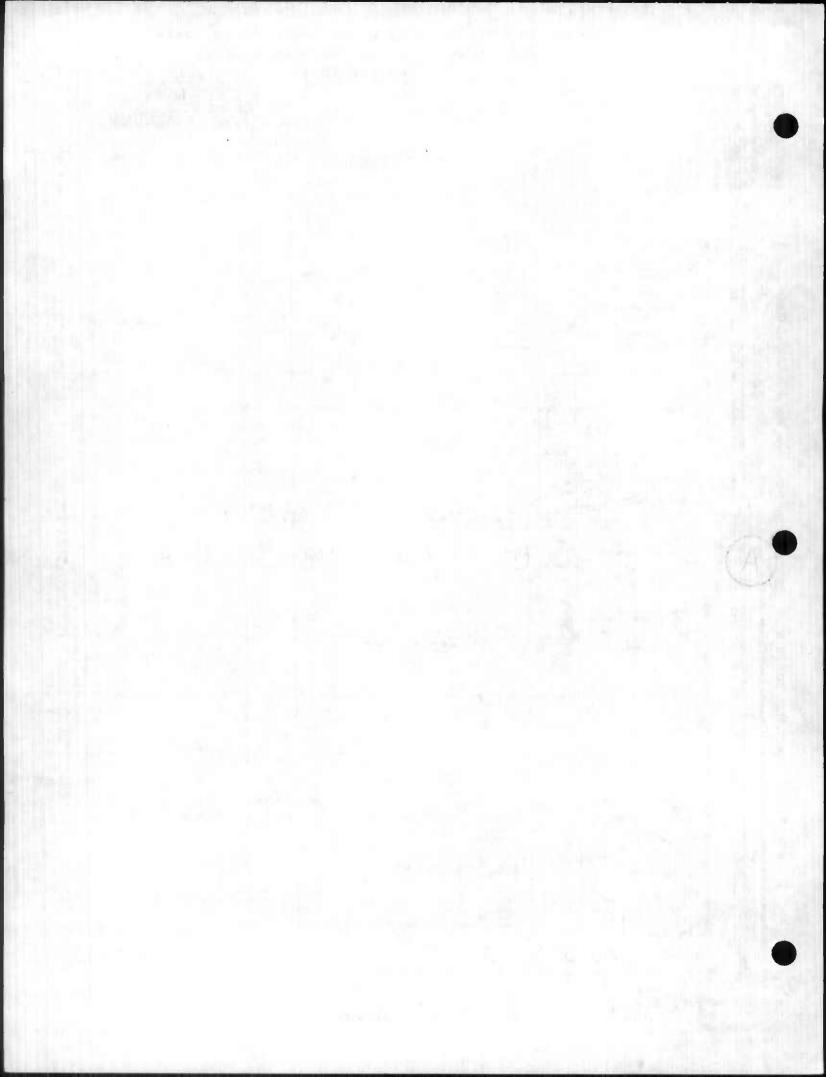
State of Maryland / Department of Health and Mental Hygiene 00 26213

				Cen	tificate of	Death		Reg. No.	eg. No.		
Physician	1. Decedent's Name (First, Middle, Inc.) Doris Irene	Guetle	r				2. Dete of D Month August	Day	Year 2000	3. Time of Death	
/Medical Examiner	4a Facility Neme (If not institution, g		or)			4b. City, Town, or Baltimo	Location of Dea		y of Death		
uneral irector	5. Sociel Security Number 220-07-9377		Age (In yrs. lest bi	rthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min	8. Dete of B	Birth 9. Bi		place (State or Foreignty) Land	
28a-f show notified at rector	Usual Residence of Decedent 10a. State 10b. County Mary Land N/A		10c. City, Tow Baltim		ation				1	10d. Inside City Limi	
be noted	10e. Street and Number	GL + 400		020	10f. Zip Code	177		10g. Citizen of			
ur, or Name 23e or 28e-fe carotine must be noticed by Funeral Director	524 N. Charles 3 11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Deceder Armed Forces	cedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. F 15. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. F 17. F 18. F 19. F 19. F 19. F 19. F 10. F 10. F 10. F 11. F 11. F 12. F 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. F 15. F 16. F 17. F 18. F 18. F 19. F 10. F					ce - Americ ck, White,	can Indian,		
item 27 is marked other than "natural", other traumatic event, the Medical East To Be Completed by	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 12	rade completed)	pleted) 16a. Decedent's Usual C (Give kind of work of life. DO NOT use in Waitress			petion during most of we d)	16b. Kind of E	Business/In	dustry		
other traumatic event, the M	17. Father's Neme (First, Middle, La Lawrence	Harris				18. Mother's Name (First, Middle Sara			me)		
er fraum	Jean C. Bronson					t and Number or F Lane Da			n, State, Zip 230) Code)	
injury or other	20a. Method of Disposition 1 🛱 Burial 2 Cremetion 3 4 Donation 5 Other (Special Content of the Content of th		cemete	ry, crem	ition (Name of atory or other ple ley Memori	al Gardens	Date 8/19/00	20c. Location Timoni		own, State Jaryland	
any injury or	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, In 6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest.										
atending physician and for use as the burial-transit claryMedical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events resulting in death) Last	a	Due to (or as a Due to (or es e	consequ	uence of):	m) q				Minute	
ed by the attend detached for us Physician	Part II. Other eignificant conditions	derlying-cause gi					to the cause of dea				
should be eted by	You (1) nson) state				24a. Wa	s an autopsy formed?	8\	fere autopsy finding vailable prior to empletion of cause death?	
Compl							10	Yes 20 No		□Yes 22 No	
rector, pa	25. Wes case referred to medical axaminer?	Hospital:			Ot	hor:	eath (Check only				
al Director: After this or led in by the funeral dire Certification: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending investigat 3 Suicide 6 Could not determine determine	be 28e. Placa of I	njury Dey Year) 28b.	Time of Injury							
To the Funeral Director: A completely filled in by the figure of the first of the f	29s. Certifier (Check only one)	Phyeician: To the besi	st of my knowledge of examination ar	e, death	occurred at the ti estigation, in my	ime, date and place	ce, and due to the	e cause(s) and n	nanner as s	stated to the cause(s)	
To the	29b. Signature and title of certifier	(Q 0	wy	0	29c. Licen	se number		29d. Data sign			
State	30. Nama and address of person whe Richard L. Diamo	ond, M.D.	f death (Item 23a) 3730 Fa strar's Signature		•	altimore	, Maryla	and 212	11		
Registrar	AUG 1 8 20	1	merra ,	9	Spark	3					



State of Maryland / Department of Health and Mental Hygiene

amend it	em 26 per verbal response 1. Decedent's Name (First, Middle, Last)	G786 8/18/00 yg	Certificate of	Death	R 2. Date of Dea	leg. No.	26214					
Physician /Medical		GOODWIN, SR.			Month August	_ Day Year	8:00 PM					
Examiner	4a Facility Neme (II not Institution, give street			4b. City, Town, or L		4c. County of De						
	Carroll County Gene 5. Social Security Number 6. Sex	The state of the s	thday) If Under 1 Yee	Westminst		Carroll						
Funeral Director	5. Social Security Number 216–24–4466 6. Sex 1 M M Usual Residence of Decedent	2□ F 7. Age (In yrs. last bird	Yrs. Months Days		8. Date of Birth (Month, Day Oct. 14	1928	rthplace (State or Foreign country) Md.					
illed within 72 hours after death with the Meryland Hydiene. If the than 'natural', or items 23a or 28a-f show hit, the Medical Everyland must be notified at the Completed by Funeral Director.	10a. State 10b. County Md. Carroll	10c. City, Town	n or Location tminster				10d. Inside City Limits 1 ☐ Yes 2 No					
rec nout	10e. Street and Number	WC3	10f. Zip Code	The state of the s	1	log. Citizen of What C	Country?					
300	903 Boxwood Ave.		211	57		USA						
si, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Meritel Stetus 12. Never Married 2 Married	Wes Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 1 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	ite, etc.					
"natural", or	15. Decedent's Education		Decedent's Usual Occi	ination		16b. Kind of Busines	lite					
then then	(Specify only highest grade co	mpleted) College (1-4or 5+)	(Give kind of work don life. DO NOT use retir	e during most of work		Esskay Mea						
191	17. Father's Name (First, Middle, Last)	T Du	Conci	18. Mother's Nem								
D 9	John Oliver	Goodwin		Theresa	R.	Hubert						
0 0 5	19a, Informent's Name/Relationship (Type,		. Mailing Address (Street									
item 27 I	Mrs. Ada Ruth Goodwi		3 Boxwood A	ve. West	minster,	Md. 21157						
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	comotor	Disposition (Name of ry, cremetory or other pi	ace)	Date	20c. Location - City o	r Town, State					
injury of	4 ☐ Donation 5 ☐ Other (Specify)		Hill Memor	ial 8	3/11/00	Middle Ri	ver, Md.					
Important: Il say injury o	22. Neme end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation of the deeth of the deet											
Examiner Lucipt I	Immediate Cause (Final disease or condition resulting in deeth) a Sequentially list conditions,	Due to (or as e o	consequence of):	MACC C	<i>b</i> cc) [MI					
g physicia es the bur fedical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last											
d lor	Part II. Other algnificant conditions contribu	uting to death but not resulting in	the underlying cause of	iven in Part I.	23b. Did to	tobacco use contribute to the cause of death?						
be detached for use by Physician/N				23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknow								
2 should					24a. Was a perfor		. Were autopsy findings available prior to completion of cause of death?					
page page					1 🗆 Y	es 2 No	1 Yes 2 No					
certificate rector, pag	25. Was case referred to medical examiner?	ital·		26. Place of Dea	1							
His T	1 Tes 2LINO	1 La Inpatient 2 LERVOu	itpatient 3LI DOA			ence 6 Other (Sp ow Injury occurred	ecify)					
ctor: After y the fune fleation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury 28d. Describe ho										
ed in b	2 Accident 3 Suicide 4 Homlcide 28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Street) 28f. Location (Street and Number or Rural Route Number of Rural Route Number											
the Funerapping fill pletch fill edical	(Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of examinetion and and manner stated.										
To the comple	29b. Signature and the of certifier /	7	29c. Lice	nse number		29d. Date signed (Mo	nth, Day, Year)					
K	· Tourok	inter M	D D3	8752		8-9-	00					
v	30. Name and address of person who comple	eted cause of death (Item 23a)	(Type, Print)									
	Flavio Kruter,	MD. 224 Was	hington H	leights N	dedical	Center	Westminst					
State	31. Dete filed (Month, Dev. Year) AUG 1 8 2000	32. Registrer's Signature	don V				Md. 211					



State of Maryland / Department of Health and Mental Hygiene 26215. Certificate of Death 2. Dete of Deeth 3. Time of Death 1 Decadent's Name (First Middle Last) **Physician** 12:45 AM 7,000 Masw TUG 4c. County of Death /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end umber) Examiner Columbia Howard Lorien Nursing Home | If Under 1 Yeer | If Under 24 Hrs. | 8. Dele of Birth (Months, Day, Yeer) | August 20, 1914 9. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 5. Sociel Security Number **Funeral** 1 M & F 85Yrs. 220-01-9212 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. tnalde City Limits 1 ☐ Yes 2 ☐ NM MD Columbia Directo Howard "natural", or thems 23s or 28s-f 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Jana.

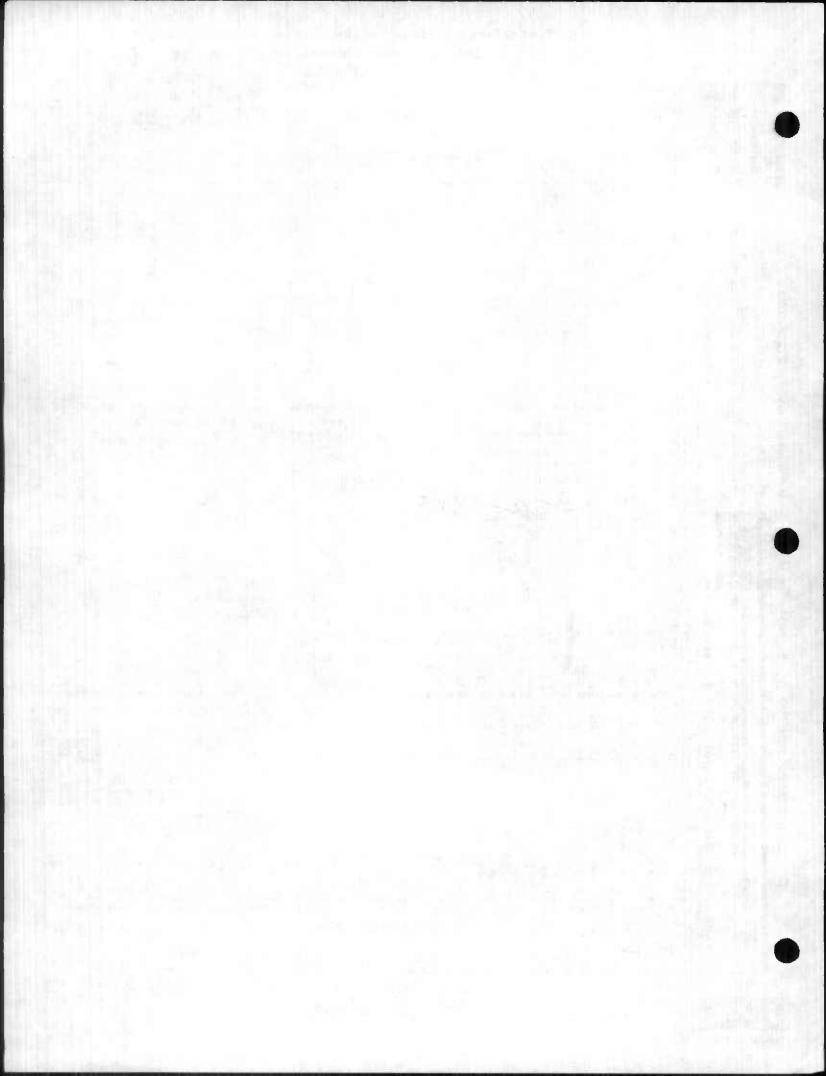
Than "natural", or items 23s or the Medical Examiner must be. 21044 U.S.A. 6336 Cedar Lane Apt 171 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Stetus filed within 72 hours after 1 Yes 2 No X If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried Maryland 21215-0020 1 Yes 2 NoX Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Insurance Elementery/Secondery (0-12) unk. College (1-4or 5+) Insurance Agent 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) should be f rnd Mental N is marked Sadie Boston Clarence Glasgow 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Important: if itsm 27 is any injury or other treum Pages 1 and 2 s ment of Health an 6260 Kind Rain Court Columbia, Maryland 21045 Mr. Michael S. Glasgow Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)
Old Mardella Cemetery 20c. Location - City or Town, Stete 20a Method of Disposition 1 ☐ Buri20 2 ☐ Cremetion 3 ☐ Removel from State 08/17/2000 Mardella Springs, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or compilitations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture? List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner DISEMIN The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events been signed by the attending physician should be detached for use as the buria Box 68760. that initieted events resulting in death) Last Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hyperteun Division of Vital Records, p 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed this certificate has 2 No 1 Yes 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred after death.

I Director: After tid in by the funera 1 Neturel 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier rellum 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Postrut Pronley 11051 32. Registrer's Signature 31. Date filed /Mont/

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 30/ Month Dev Year 4b. City, Town, or Location of Death VOLAN 2000 4a Facility Name (If not institution, give stre 4c. County of Deeth t and number) Baltimore HOPKINS CENTER Tric If Under 1 Year If Under 24 Hrs. 8. Dete of Birth MAR 14 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birtholaca (State or Foreign Months Days Hours 1X M 2 F 67 BALTIMORE, MD. 218-28-1836 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7944 BELRIDGE ROAD APT. A 21236 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEAMAN MERCHANT MARINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWIN HURTT ADDISON ELIZABETH 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY FRANKLIN/SON-IN-LAW 2803 ONYX ROAD PARKVILLE, MD. 21234 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stata matory or other place) Ty Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) OAK LAWN 8/16/00 BALTIMORE, MD. 21. Signature of Funeral Service Licen 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. 23a. Pant. Enter the disease, or complication. Ital caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately a such as cardiac or respiratory errest, Approximately a such as cardiac or respiratory errest, Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Years Years multi Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? ulcers to sacrum (B) & Ohee 2E No 218 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? 28b. Time of 5 Pending

Attending Physician: The law requires that the death certificate be executed the buriel-transit Box 68760 for use as Division of Vital Records, P.O. been signed by the should be detached hes cartificate funeral director, shia Affer To the Hospital or Attendin within 24 hours after deeth. To the Funerel Director: Aft completely filled in by the fur

Physician

Examiner

Funeral

Director

ehow.

permit. Pages 1 and 2 should be filed within 72 hours after death with the M. Department of Health and Mentel Hyglens. Important: If item 27 is marked other tha. "naturel", or items 23s or 28s-f. emprortant: or other treumstic event, to Medical Espains. That he notine page.

Physician

/Medical

Examiner

Director

Funeral

Completed by

8

death with the Menyland

21215-0020

Baltimore, Maryland

/Medical

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Completed teomyelitis Be 25. Was case referred to medical examiner? 1 Yes 2 No edical Certification: To 27. Manner of Death 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1ii Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ž 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) 8

Kymbaughn

CRNP 5505

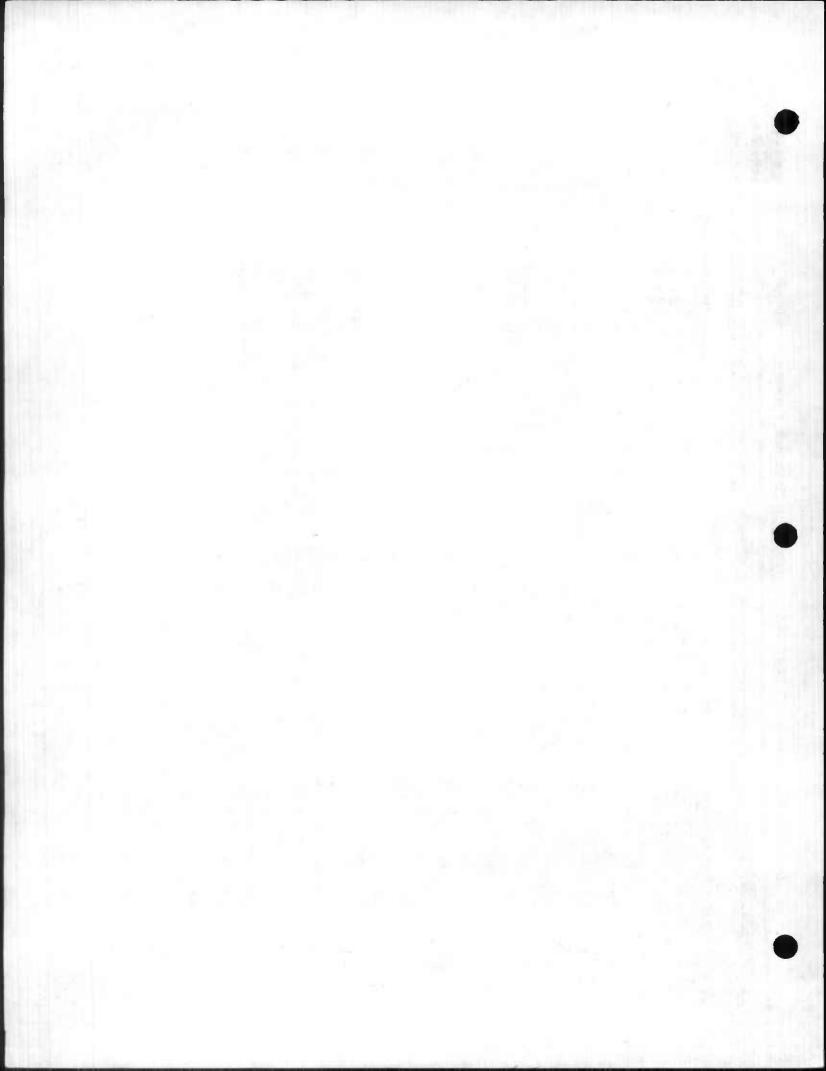
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Horking Barner 32. Registrar's Signeture

D47479

15/00

ORIGINAL



1 Decedent's	Nama (First Middle 1			E Certificate of	Dodin	Re	g. No.	
	reame (First, Middle, L		nd Jos	eph Hamil	ton	2. Dete of Deall Month AUGUST		3. Time of Death 10:10 P.M.
					4b. City, Town, or L JESSUP	ocation of Death	4c. County of De ANNE A	ath ARUNDEL
220-40	-7880	Sex NOM 2□ F		Months Dev		8. Date of Birth (Month, Dey, Aug 5,		irthplace (State or Foreign Country)
10a. State	10b. County	Arundel	10c. City, To	wn or Location Jessup				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	and House				20794	10		Country?
3 □ Widow	tus Married 2□ Married	12. Waa Decedent Armed Forcas?	Ever in U,S.	If Yes, specify Cu	ban, Maxican, Puarto	pecify Yas or No- Pican, etc.)	14. Race - Am Black, Wh Specify:	narican Indian, lita, etc. White
			166	a. Decedent's Usuel Occ (Give kind of work don	upation e during most of work	king	16b. Kind of Busines	s/Industry
Elementery/		College (1-4or !	5+)				Ship Ya	ard
17. Father's N			Sr.					
19a. Informan						C	len Burr	nie, MD
1 🗆 Buria	2X Cremation 3		cemel	tery, crematory or other p			20c. Location - City of	or Town, State
21. Signeture	Funerel Service Lic	onsen 1		Burge		Seitz F	uneral F	Home, Inc.
	MARYL 5. Social Secur 220-40- Usual Resident 10a. State Maryla 10e. Street and 10e. Street 10e. Street and 10e. Street 10e.	MARYLAND HOUSE 5. Social Security Number 220-40-7880 Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number Maryland House P.O. Box 534 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Mivorced (Specify only highest g Elementery/Secondery (0-12) 6 17. Father's Name (First, Middle, Last Carroll E. 19a. Informant's Name/Relationship Albert W. Hami 20a. Method of Disposition 1 Burial 2 Micremation 3 4 Donetion 5 Other (Speci	MARYLAND HOUSE OF CORRECT. 5. Social Security Number 6. Sex 220-40-7880 WMM 2 F 220-40-7880 WMM 2 F 220-40-7880 WMM 2 F 220-40-7880 WMM 2 F 7. Ag 7. Ag 7. Ag 220-40-7880 WMM 2 F 10b. County Maryland Anne Arundel 10e. Street and Number Maryland House of Corre Amed Forcas? 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tot Maryland Anne Arundel 10e. Street and Number Maryland House of Correction P.O. Box 534 Route 175 11. Marital Status 12. Waa Decedent Ever in U.S. Armed Forcas? 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Norced 175 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 6 17. Father's Name (First, Middle, Last) Carroll E. Wilgis, Sr. 19a. Informant's Name/Relationship (Type, Print) Albert W. Hamilton, Sr. (Bro 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify)	MARYLAND HOUSE OF CORRECTIONS 5. Social Security Number 20-40-7880 Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel 10c. City, Town or Location Maryland House of Corrections P.O. Box 534 Route 175 11. Marital Status 1 Descedent a Education (Specify only highest grade completed) Elementery/Secondery (0-12) 6 17. Father's Name (First, Middle, Last) Carroll E. Wilgis, Sr. 19a. Informant's Name/Relationship (Type, Print) Albert W. Hamilton, Sr. (Brother) 10b. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10d. Zip Code 10d. Zip Code 11d. Was Decedent or 11d. Was Decedent or 11d. Was Decedent or 11d. Yes, specify or 11d. Yes, Specify or 11d. Yes, Specify or 11d. Was Decedent or 11d. Yes, Specify or 11d. Yes, Specify or 11d. Was Decedent	MARYLAND HOUSE OF CORRECTIONS 5. Social Security Number 6. Sex 220-40-7880 Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel 10c. City, Town or Location Maryland House of Corrections P.O. Box 534 Route 175 11. Marital Status 12. Was Decedent Ever in U.S. 3 Widowed 4 Married 3 Widowed 4 Married 3 Widowed 4 Married 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Carroll E. Wilgis, Sr. Maryland Anne Arundel 10c. City, Town or Location Jessup 10f. Zip Code 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Maxican, Puerto Hyse, Giva Yasar or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Carroll E. Wilgis, Sr. 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. Do NOT use retired) I. Long Shoreman 17. Father's Name (First, Middle, Last) Carroll E. Wilgis, Sr. Mary 19a. Informant's Name/Relationship (Type, Print) Albert W. Hamilton, Sr. (Brother) 20b. Place of Disposition (Neme of cemetery, crema tory or othar piece) Chesapeake Crematory 21. Signeture of Funerel Service, Licenum 22. Name and Address of Facility Burgee-Henss-	MARYLAND HOUSE OF CORRECTIONS JESSUP	MARYLAND HOUSE OF CORRECTIONS 5. Social Security Number 6. Sex 10. Sex 10. Sex 10. City, Town or Localion Maryland Anne Arundel 10. Street and Number Maryland House of Corrections 10. Street and Number r Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Number or Rurel Route Number, City or Town, State 10. Street and Numb

Be Completed by Physician/Medical Examiner

for

use as the burial-tran cate has been signed by the a page 2 should be detached Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be asscuted

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es a consequence of):

Due to (or as a consequence of)

Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to complation of causa of death?

1) Yes 2□ No Yaa 2 No

25. Was case referred to medical axaminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 3 DOA

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Katural 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Yes 2 No

2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end manner es stated

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E. august 13,2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

JACK M. TMS, M.D. 1111 Penn Street, Baltimore, Maryland 21201

State Registrar

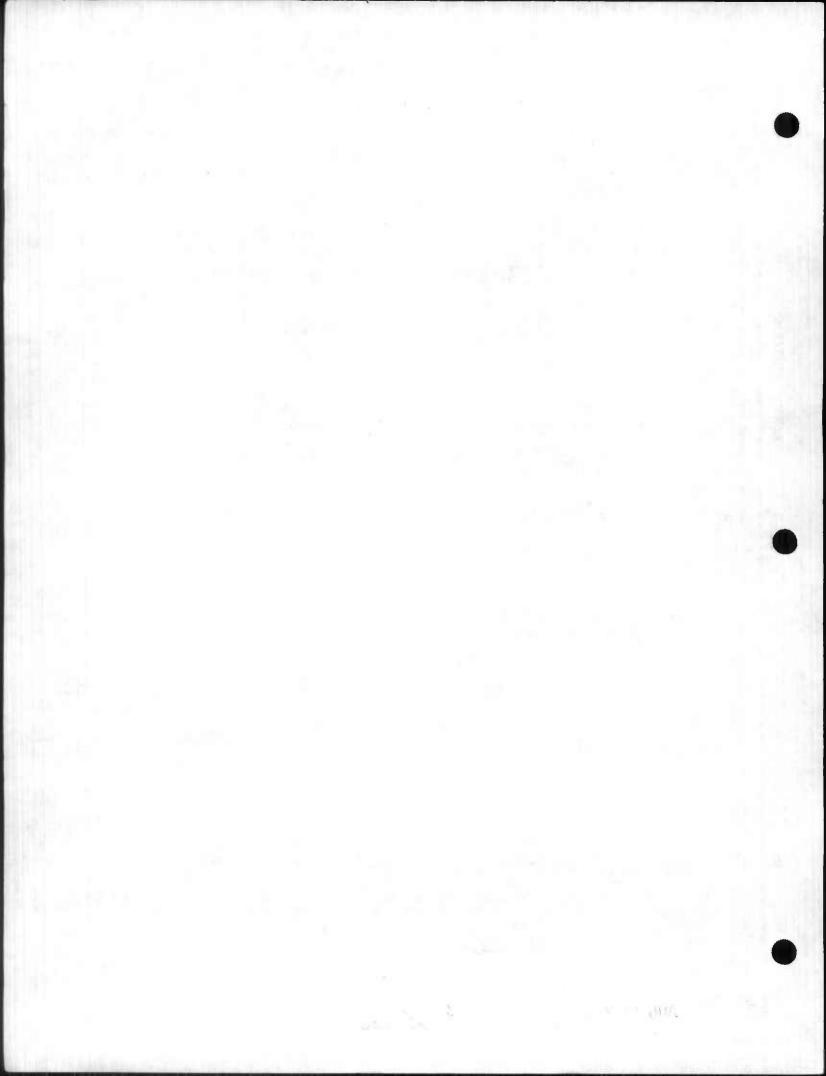
29b. Signatura and title of certified

32. Registrar's Signature

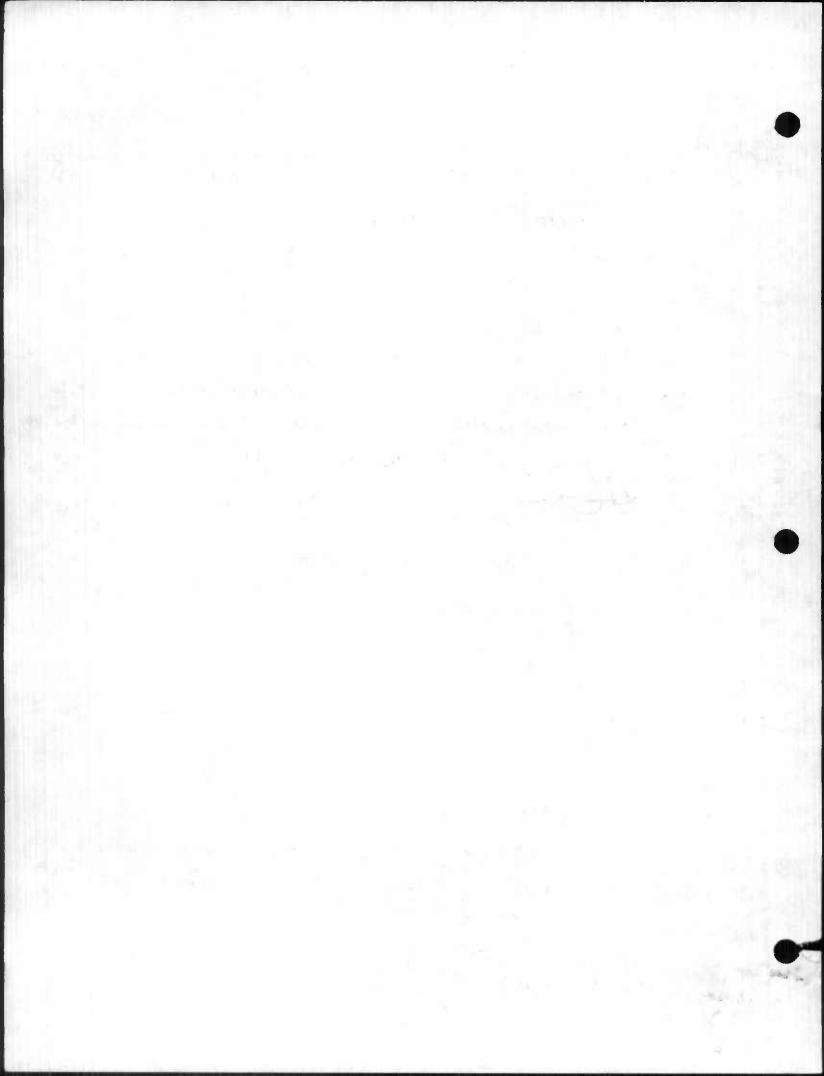
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within 24 hours aftar death. To the Funeral Director: A

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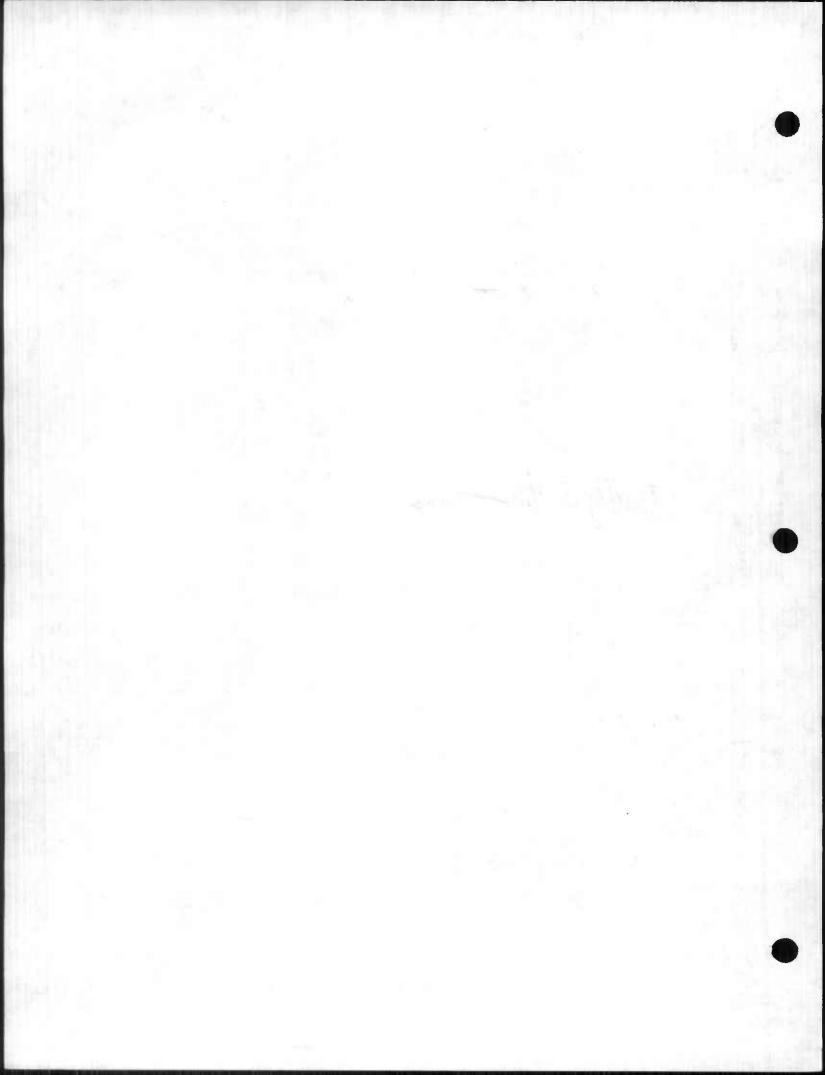


Physician	_	. Decedent's Name (First, Middle, La	ist)			2. Date of Death Month	Day	3. Time of Death
/Medica	_	Cynthia	J. Hintor	1		AUG. 12		
Examine		e Facility Name (If not institution, giv SINAI HOSPI			4b. City, Town, or BALTIMOR		4c. County	
uneral Director		Social Security Number 6. S 212 - (a 0 - 5 5 7 0) Sual Residence of Decedent	Sex 7. Age (In yrs. 47	Asst birthday) If Under 1 Year Months Deys		(Month, Dey,	Year) 152	9. Birthplace (State or Fore Country) Mary and
fied at	1	Oa. State 10b. County	A 10c. Cit	y, Town or Location Baltimore				10d. Inside City Lim
r mat be notified at		0e. Street and Number 1947 N. Pay	son St.	10f. Zip Code	1217	10	g. Citizen of W	Vhat Country?
and a	oy runer	1. Merilel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Deles:	S. 13. Was Decedent of if Yes, specify Cul		Specify Yes or No- to Ricen, etc.)		e - Americen Indian, ik, White, etc.
er than 'naturn t, the Medical 2	Dieted	15. Decedent's E (Specify only highest gre	ede completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation e during most of wo ed)	rking		siness/Industry
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	ToBe	- 1 -	hnson			nie B		
men b		19a. Informant's Name/Relationship (19b. Meiling Address (Street	et end Number or R	urel Route Number,		Stete, Zip Code)
27.		Mrs. Lennie B	sall (mother	124 W. F	runklin ?	of But	· MD	21201 (Apt. 1
and and	2	Oa. Method of Disposition	20b. P	lece of Disposition (Neme of semetery, cremetery or other pl	(ece)			City or Town, State
A DE LE		1 Surlal 2 Cremation 3 4 Donation 5 Other (Specif	JHemovei from State	ut Zion Cem		8/18/2000		donne, MD
S TO S		21. Signature of Funeral Service Lice	osea	22. Name end Addi	ress of Facility	so Fint	enal S.	envice, P.A
5 3 3		XHX		709	Tessie		alt.	MD 21201
ysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.			c or respiratory arres	SI,	Approximate
Medical aminer	1.0	Immediate Cause (Final disease or condition resulting in death)	. GUNSHOT (Wourds (2) of	,	c or respiratory arre-	51,	Interval Between
aminer		disease or condition resulting in death)	b. GUNSHGT (Nound 5(2) of or es a consequence of):	,	c or respiratory arre-	51,	Interval Between
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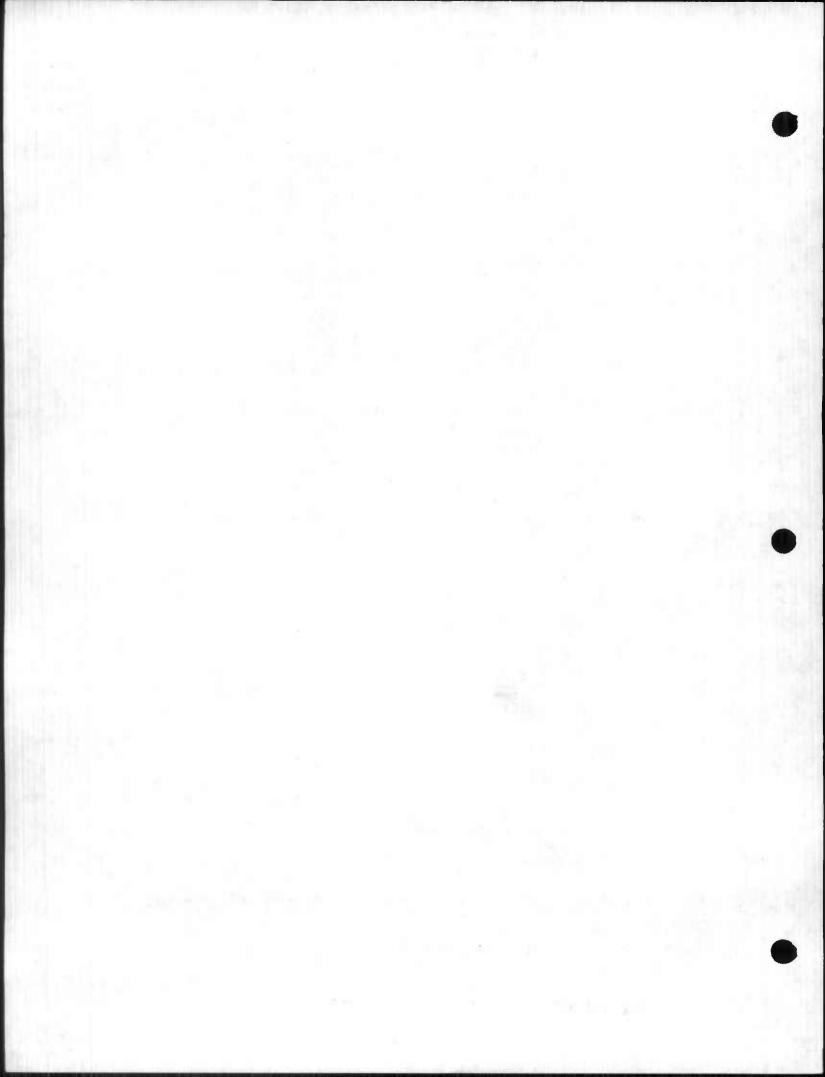
State of Maryland / Department of Health and Mental Hygiene 00 26210.

Amended I	tem#12 perDVR G786 8/18	3/2000 EW	Cei	rtificate of	Death		Reg. No.	9	-0213
	1. Decedent's Name (First, Middle, Las	nt)				2. Date of De	ath Day	Year	3. Time of Death
Physician /Medical	William	E Junis				Augus		2000	6=20 AM
Examiner	4e Facility Name (If not institution, give				4b. City, Town,	or Location of Deet			
	How	ard County General	Hospital			Columbia		H	loward
Funeral Director	217-20-7837	ex 7. Aga (In yrs.	last birthday) 88 ^{Yrs.}	Months Days		s. B. Date of Bir (Month, De Novem	th <i>y, Year)</i> ber 23, 191	9. Birthpla Countr	ace (State or Foreign ry)
aryland show d.at	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10	d. Inside City Limits
M at the post of t	Maryland	Howard		1	Ellicott C	ity			
Seath with the Maryla ms 23s or 24s-f sho must be notified at neral Director	10e. Street and Number 3368-A N. Chatham	n Road		10f. Zip Code		042	10g. Citizen of V		.S.A.
020 urs atter at., or the Examine by Fur	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 17 Yes x 25 Ho If Yes, Give Year or Dates:	1010	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 KN	ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		e - America k, White, el	
5-0 72 hr	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occi	upation e during most of i	vorkina	16b. Kind of Bu	sinass/Indu	ustry
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	17. Father's Neme (First, Middle, Last)				18. Mother's h	lama (First, Middle	, Maiden Suman	10)	PREFER
Viar Menta Menta mile ev	Pe	eter P. Junis					Louise E	lilliet	
Maryland 42 should be file h and Mental Hy l is merked othe traumatic event	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stree	et and Number or	Rural Route Numb	er, City or Town,	State, Zip (Code)
M Sales	Linda C. Cave	y Daughter		6621 Mai	Marvin Ave. Eldersburg, Maryland 21784				
More, Papes 1 a sent of He mt. If Item	20a. Method of Disposition 1 Burixt 2 Cremation 3 4 Donation 5 Other (Specify	Hemovel from State	Place of Dispo cemetery, crei Crest I	sition (Name of matory or other pi Lawn Memo	lace) rial Gardens	Date 08/19/200	20c. Location -		vn, Stete
Baltii pemit. 9 Departm Importan any injur	21. Signature of Fuguera Service Licen	see the	- 1	2. Name and Add	ack Funeral	Home, P.A.		4D 0404	
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DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (yeiclan: To the best of my kno niner: On the basis of examina and manner stated.							
ithin on the omple	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signe	d (Month, D	Day, Year)
F 3 F 8	1 deal	ALM		1	31927		aug	. 17.	2000
6	30. Name and address of person the	V	()			lumbra	nik 5	2000	2000
	10 000 100	up. Iwo K	noll /	vorth k	the Col	um Bia	, /ND /	1043	b
State Registrar	31. Date filed (Month, Day, Year)	32. Registrer's Sign	eture 4	low	No				



State of Maryland / Department of Health and Mental Hygiene

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To	CHAR	RLES MALLO	ORY					HENRI	ETTA M	IALL	ORY			
	19a. Informant's Name/Relationship Norma Weldon/Nieo		(Type, Print)		19b. N	Mailing Addre	ss (Street	and Number or i	iural Route I	lum <i>ber</i> ,	City or Tow	n, State, Zi	ip Code)	
	Norma Wo	ldon/Nico	26		44	09 Par	ere I	or., Vir	ginia	Rea	ch - 177	2. 2.	3456	
	20a. Method of D	isposition			b. Place of D	Disposition (N	lame of		Date		Oc. Location			
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death August 16, 2000 **Physician** Arthur Stuart Jordan 3:20 a.m. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner Gilchrist Center For Hospice Care Baltimore Towson H Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours Maryland NOM 20 F 87 Yrs. Jan. 14, 1913 215-05-8434 Director Usual Residence of Decedent 10d. fnside Clty Limits 10b. County 10c. City, Town or Location or 28a-f ahov the Medical Examiner must be notified at 1 Yas 2 No Funeral Directo Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204-2041 U.S.A. 8432 D Charles Valley Court 234 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. or Nema 11 Merital Status filed within 72 hours after NO Yes 2 No if Yes, Give Yeer or Detes: WW II 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify. Specify: White Completed by 3X Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Indus. Pro . Adm. Edgewood Arsenal .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 Is marked other it jury or other traumatic avant, in Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Herbert Robinson Jordon Anna Stuart Green 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Claire J. Cann / Daughter 1032 Hidden Moss Drive Hunt Valley, Maryland 21030 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burlal 2 Cremetion 3 Removal from State Department of Important: If any injury or Owings Mills, Maryland Garrison Forest Cemetery 8/21/2000 4 Donation 5 Other (Specify) L. Canapp, CFSP 21. Signeture of Paperel 22. Name end Address of Fecility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 only one cause on sech line. Approximate tntarval Between Onset and Death **Physician** /Medical immediate Cause (Finel monthy disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es a consequence of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 20 No 3 Probably 4 Unknown ۵. by Records, 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24e. Wes en eutopsy The law 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital Hospital or Attanding Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICe 1 Yes 2 No Medical Certification: To 2 o 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 50 1 Netural Division 5 Pending death. investigation 1 Yes 2 No 2 ☐ Accident after deatl Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

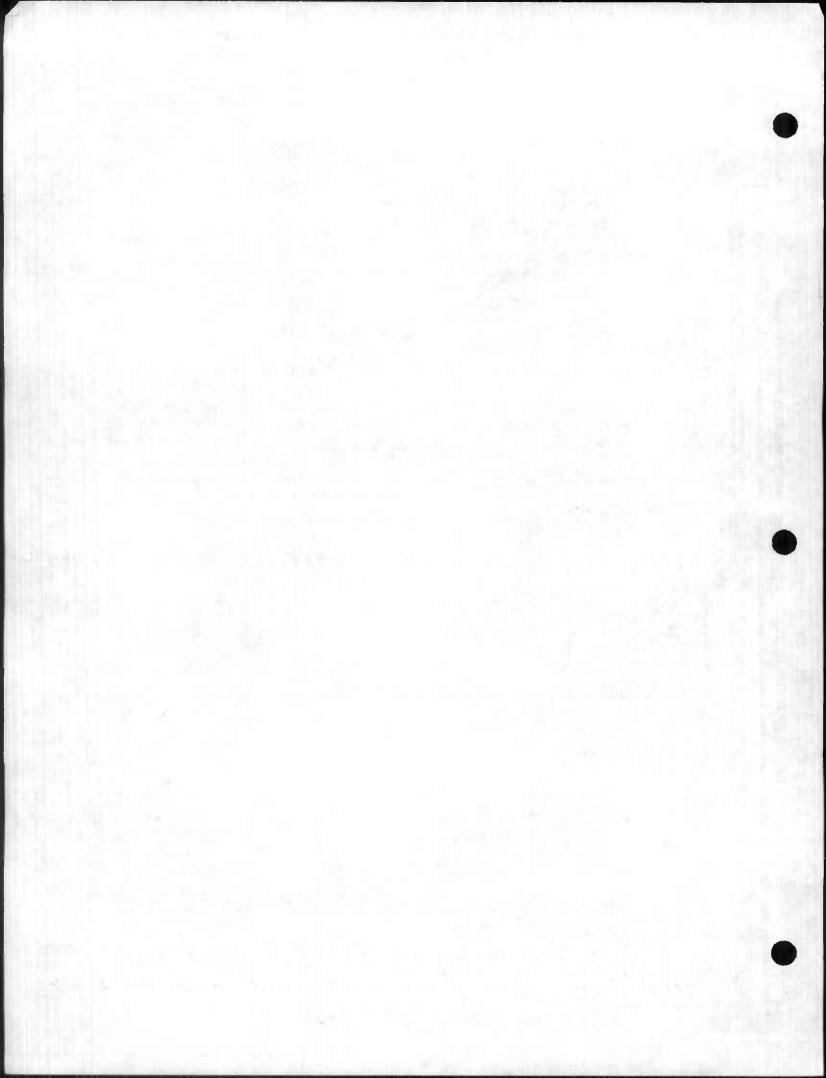
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the To the 29d_Dete signed (Month, Dey, Year) 29b. Signeture and who of prefiles 29c. License number and 30. Name and address of person who completed cause of days (Type, Print) N. Charles St. Balto. Md 21205 16-BmC 31. Date filed (Month, Day, 32. Registrer's Signature AUG 1 8 2000 Registrar

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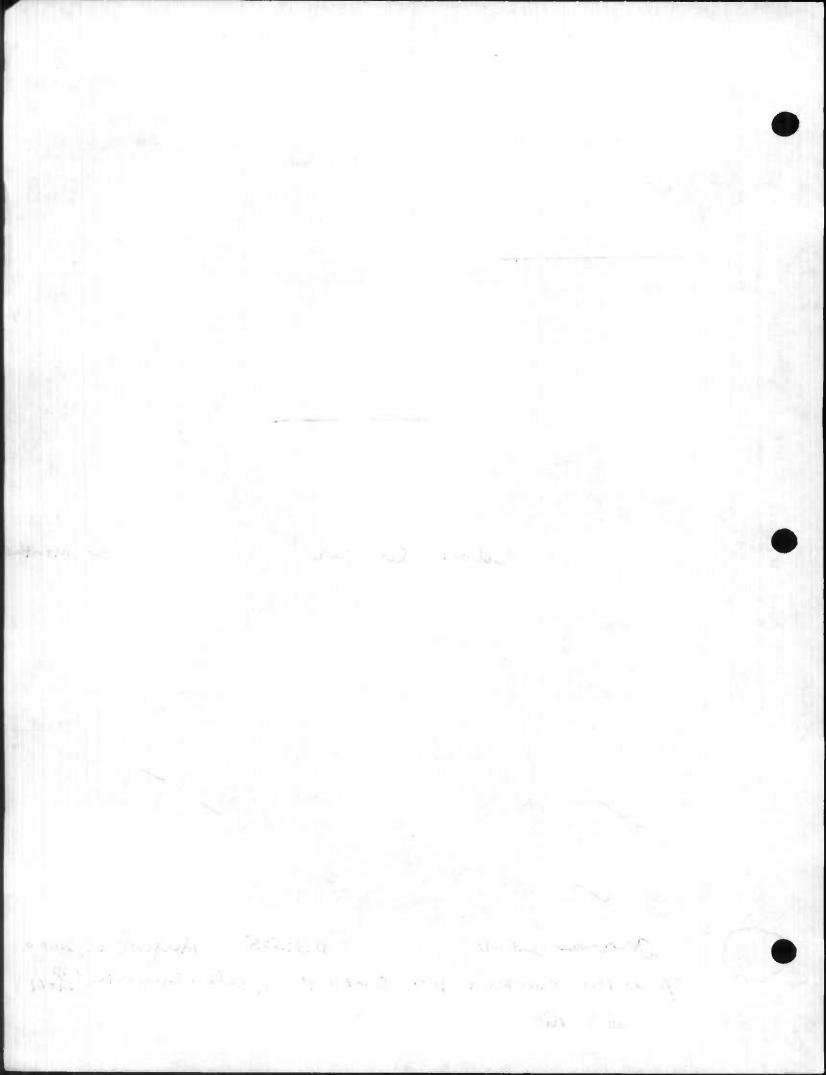
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/Medical Examiner	4a Facility Name (If not inst			ımber)	- 1		4b. City, Town, or I			ty of Death		
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uneral rector	5. Social Security Number 214.30.7272		ox ÖXM 2□F	7. Age (In ye	rs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/6/1	th ay, Year) 933	9. Births Cour Maryl	place (State or For etry) and	
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eve a	17. Fathar's Name (First, Mi	odle, Last)					18. Mother's Nan			ime)		
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and Il-transit Xamlr	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last	1	b	Due to	o (or as a conse					1		
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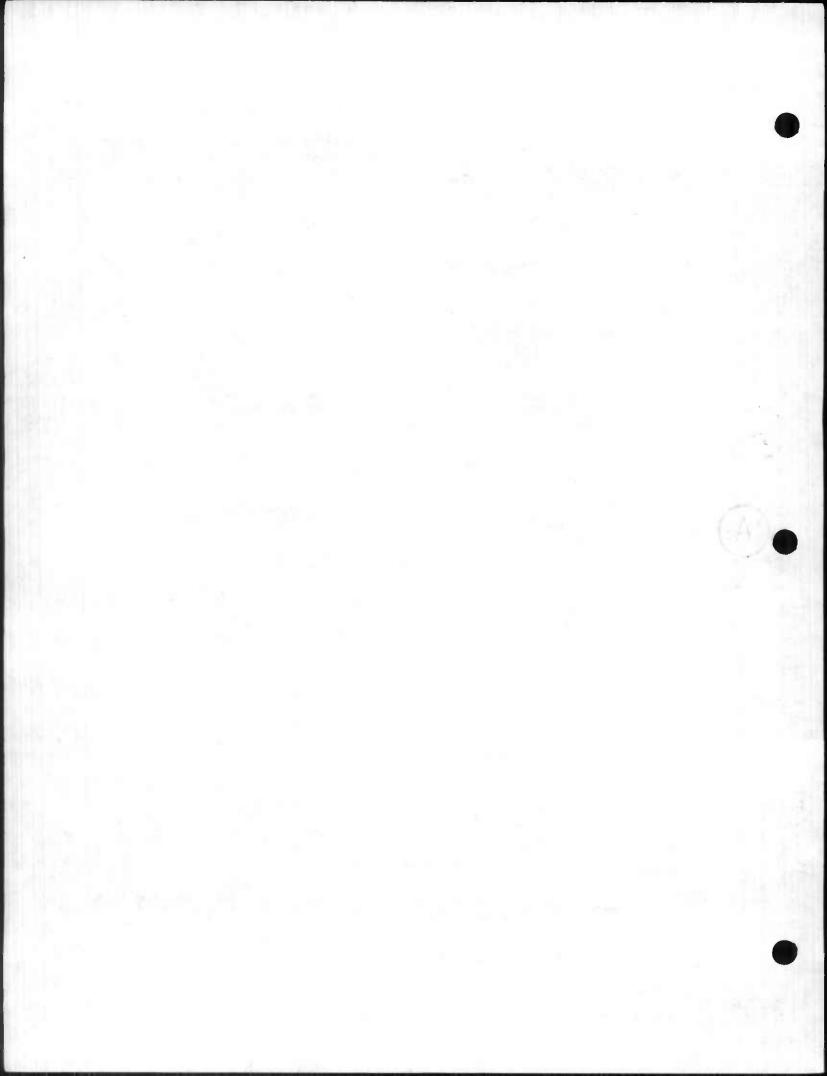
DHMH 16 Rev 6/95



Piease Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legible. 29d State of Maryland / Department of Health and Mental Hygiene 29d State of amend item 29c per phys. G786 8/18/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 03,2000 005EUEL 12,25 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street end number) **Examiner** Baltimore St. Algnes Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months 240-12-360 Usual Residence of Deceden 15 M 20 F Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23a or 28a-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director aUTIMO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.5A EES 1316 filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 11. Marital Status 1 Nas 2 No if Yes, Give Year or Dates: WWIL 1 Nevar Married 2 Married Maryland 21215-0020 1□ Yes 25 No Specify þ BUACK 3 Widowed 4 □ Divorced To Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) LOGGER NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme, Pages 1 and 2 should be nent of Health and Mental int: If Itsm 27 is marked or KEEMER 5 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is sny injury or other treu once. 1316 20c. Location - City or Town, State REDAIE / 20a. Method of Disposition KEMMER/SON Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetery or other place) Date Burial 2 Cremation 3 Removal from State 100 4 □ Donation 5 □ Other (Specify) PARRISON FOREST 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility nauce ACOLINE ST-23a. Part1. Finer the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest shock of heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /interligation Examiner Due to (or as a consequence of) Physician/Medical Examiner senosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last hull Due to (or as a consequenca ot): Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 GOnknown Be Completed by 24b. Were autopsy tindings available prior to completion of cause ot death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28d. Describa how injury occurred Division Attanding 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier 29c. Licanse number 29d. Date signed (Month Bey, Year) 29b. Signature and title of certities P13133 Sokarzyoury 30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print) Sterling 20164 410. N. ARGONNE YOUSIL-Are SOHAIR 31. Date tiled (Month, Day, Year) 32. Ragistrar's Signatura State AUG 1 8 2000 Registrar

DHMH 16 Rev 6/95



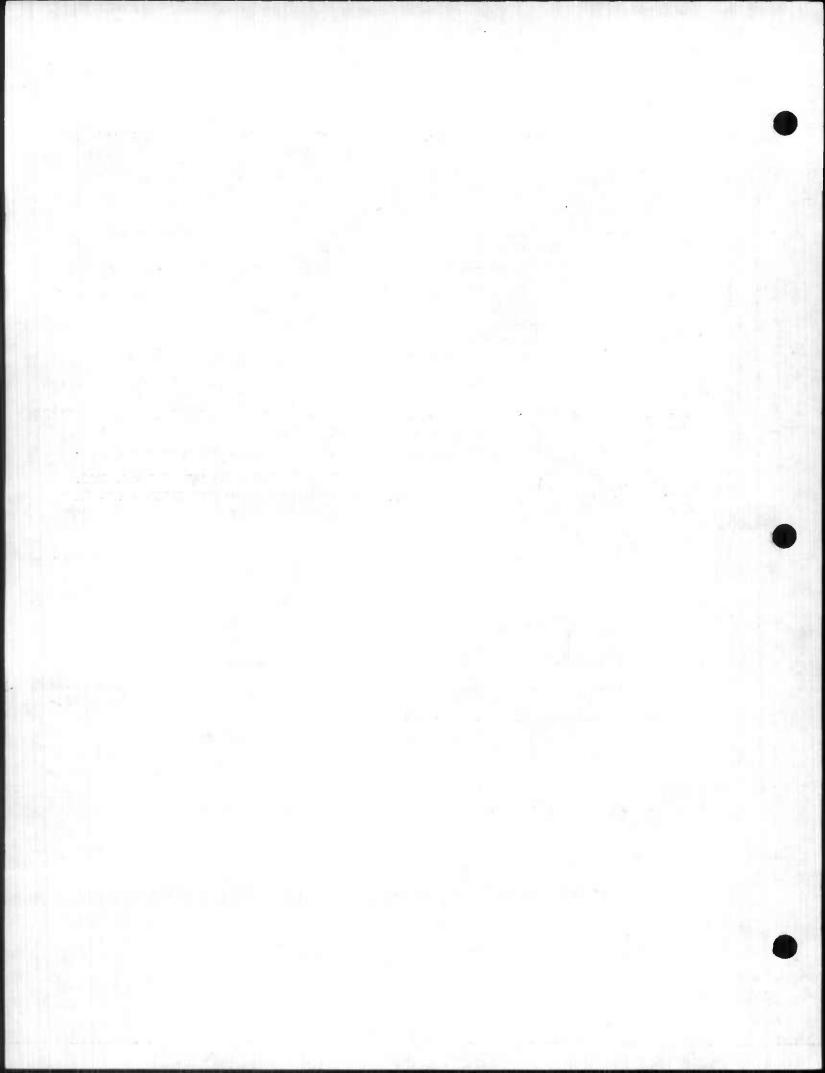
1. Decedent's Name (First, Middle, Last)

Physician /Medical	KHAVA	KIP	NIS			AUG	13 ^{Day} 20	9PM	
Examiner	4a Facility Neme (If not Institution, giv		LIOME		4b. City, Town, or				
Funeral Director	FUTURECARE—CHERRY 5. Sociel Security Number 217—35—9466		rs. last birthday)	If Under 1 Year Months Days		. 8 Date of B		PIMORE 9. Birthplace (State or Foreign RUSSIA	
Maryland f show	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORI		City, Town or Loca EISTERSTY					10d. Inside City Limits 1 ☐ Yes 2 1 No	
death with the Maryland ms 23e or 28e-f show mast be notified at neral Director	10e. Street and Number 28 BROOKEBURY DRIV	VE APT. 1-C		10f. Zip Code 21	136		10g. Citizen of U.S.A.	What Country?	
Urs after	11. Marital Stetus 1 Nevar Married 2 Married Widowed 4 Divorced	12. Wes Decedent Evar In Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Detes:	N.	as Decedent of I res, specify Cub	Hispanic Origin? (Span, Mexican, Puer Specify:	specify Yes or Noto Rican, etc.)	Bla	ce - American Indian, ck, White, etc.	
s within jiene.	15. Decedent's E (Specify only highest gra Elementary/Secondery (0-12)	ducation ide completed) Collega (1-4or 5+)	(Give ki	nt's Usuel Occu nd of work done NOT use retire	petion during most of wo ad)	rking	16b. Kind of B	usiness/Industry	
yianc buid be fi Mental H Mental H arked out arked out	17. Father's Nema (First, Middle, Last, MAYER	KIPNIS			18. Mother's Nat FAIGA		e, Maiden Suman OBTAINAE	ne)	
e, Mar 1 and 2 sh Health and Pm 27 is m ther traum	19a. Informent's Neme/Reletionship (ALEKSANDER SHRAYBI	MAN/SON	28 BRO	OKEBURY	DR. APT.			State, Zip Code) WN, MD. 21136	
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Baltim permit. Per Department important: any injury.	21. Signatific of Funeral Strvice Life	Mia		Name end Address	SC			ROS. INC.	
Physician /Medical Examiner	23a Part Enter the disease, or complete the control of the control	· CERLEBIL		MBOS		c or respiretory	arrest,	Approximate Interval Between Onset end Death	
). Box 68760, deeth certificate be executed he attending physician and ed for use as the burial-transit stclan/Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events rasulting in death) Last	C	(or as a conseque						
P.O. d by the detacher	Part II. Other significant conditions of						l tobacco use co] Yes 2 □ No	ntributs to the cause of death?	
ew requires been a 2 should						24a. We per	s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
Vital Relations The light certificate he rector, page						10	Yes 2010	1 ☐ Yes 2 ☐ 116	
Of Vita Physician: this certific ral director, To Be	25. Was case referred to medical examinar? 1 Yas 2 No	Hospitel: 1 ☐ inpetient 2	☐ ER/Outpatient	3□ DOA Ot	26. Place of De		one) idence 6 □Ott	ner (Specify)	
ision tranding deeth. ctor: After y the fune	27. Manner of Deeth 1 Danatural 5 Panding 2 Accident Investigation 3 Suicide 6 Could not be	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	M 28c. tnju Wo	ry at ork?] Yes 2 □ No	28d. Describe	how injury occur	red	
Div To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certit	28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28e. Plece of injury - At home, ferm, street, fectory, office City or Town, State) 28f. Location (Street and Number or R City or Town, State)								
To the Hospital within 24 hours or To the Funeral completely filled Medical Co	(Check only 2 Medical Example) 29b. Signature end title of certifier	iner: On the basis of examined and menner stelled.	netion and/or inve	29c. Licens	se number	irred at the time		and due to the cause(s) id (Month, Day, Year)	
N	30. Name and address of person who	completed cause of deeth (Ite	em 23a) (Type, Pr		5931			- 14, 2000	
State	Deborah I /	32. Registrar's Sig	aao PAY	LIC ITET	IGHTS A	E BA	LTIMOY	LE. MO 2120	
Registrar	AUG 1 8 20	00 Deneuro	B	Spark	2				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

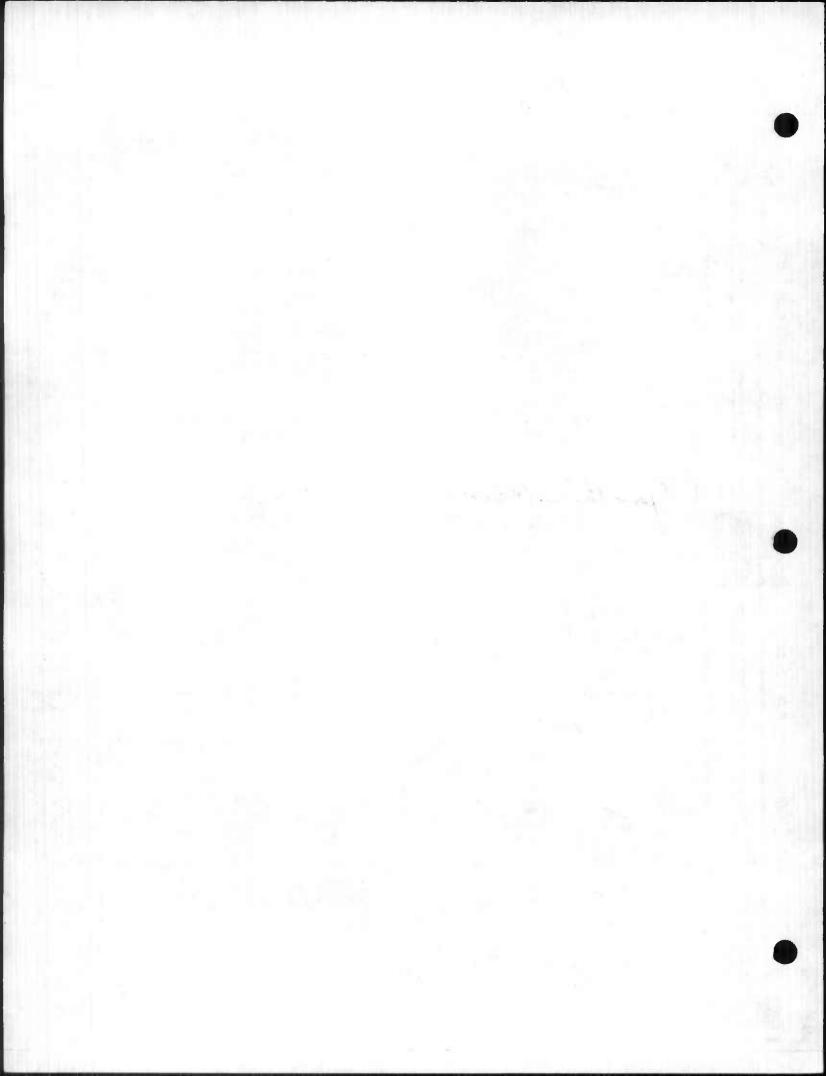
2. Date of Death



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 3. Tima of Death 2. Dete of Death Month Day Year **Physician** Jacqueline Mary Kidd 11:28 Am August 10 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Northwest Hospital Randallstown BALtimare If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) **Funeral** 1□M 2□F Months Director 220-52-3898 51 8-6-1949 MD. Usuel Residence of Deceden the Maryland 10a. State 10c. City, Town or Location r 28a-f ahow 10b. County 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director MD. BALTIMORE CORTLEIGH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r hems 23s or 2 40 WESTERN WINDS CIRCLE 21244 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Merital Status nit. Peges 1 and 2 should be filed within 72 hours aftar di serment of Heelih and Mentel Hyglann. Ordant: If team 27 is marked other than "natural", or hen Injury or other traumatic event, the Hindian Estational. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: by Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry Elementery/Secondary (0-12) College (1-4or 5+) -12--2-HEALTHCARE ADMINISTRATOR GOVERNMENT Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JAMES KIDD MARGARET GREEN 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) RYAN GREENE (SON) 3980 RED DEER CIRCLE RANDALLSTOWN, MARYLAND 21133 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 17 Burial 2 Cremetion 3 Removel from Stata
1 Donation 5 Other (Specify) permit. Pege Department o Important: If I any Injury or once. 4 Donation DRUID RIDGE CEMETERY 8-15-2000 BALTIMORE, MARYLAND 22. Name and Address of Fecility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirely arrest, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiac arrhythmia Minutes Examiner Due to (or as a consequence of): Physician/Medical Examiner Hemoglobin SC Asecs & The law requires that the death certificate be executed the buriel-trans Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Due to (or es e consequence of): for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Bunknown hyportension þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed certificate has Tes 2 No METOS 2 No or Attending Physician: funeral director, 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 100 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? After 5 Pending investigation 1 Divetural 1 Tyes 2 □ No To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: All completely filled in by the fu deeth. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide **Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and fille of contilled 29c. License number 29d. Date signed (Month, Dey, Year) August 11, 2000 DY3453 m (Item 23a) (Type, Print) 30. Neme and address Northwest Hospital, Randallston WD V. DiKon

State Registrar 31. Date filed (Month, Day, Year) AUG 1 8 2000 32. Flagistrar's Signeture

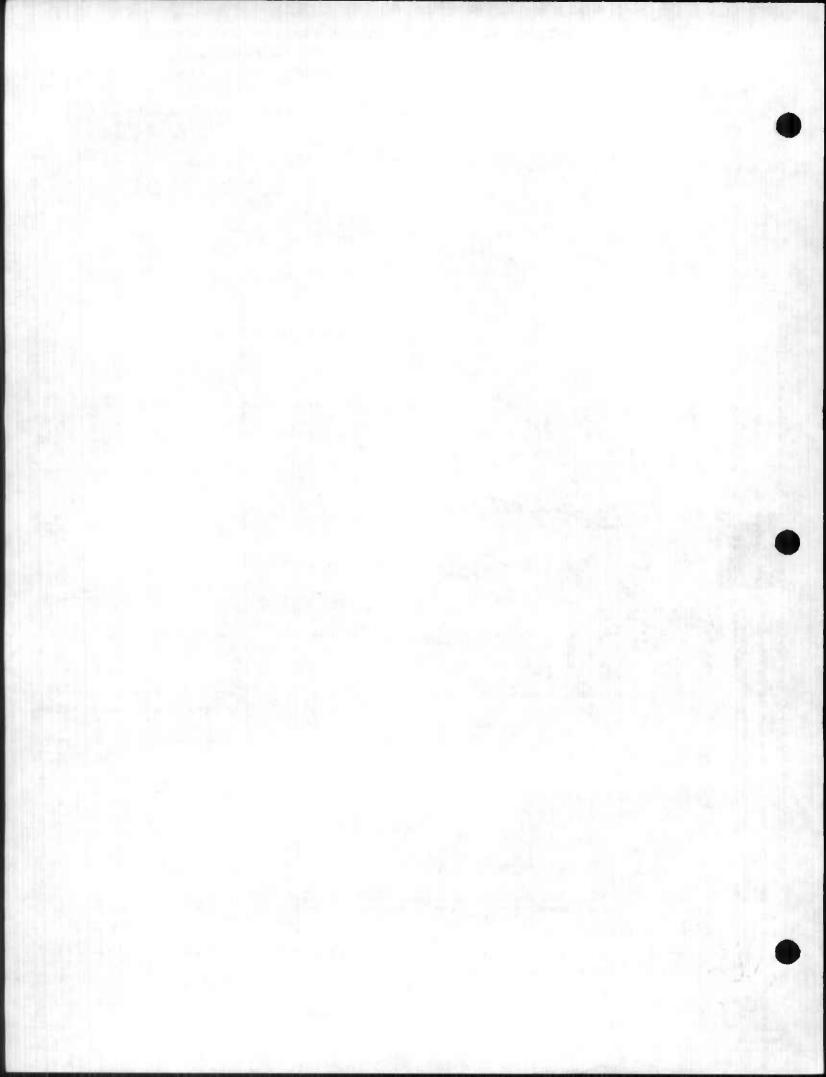


State of Maryland / Department of Health and Mental Hygiene

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			Certifica	te of Death	Re	g. No.	79551
sician	1. Decedent's Name (First, Middle, L.	nst)	11116		2. Date of Death Month	Day Year	3. Time of Death
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niner	4a Facility Name (If not institution, gi			Baltim		4c. County of Death	
eral ctor	216-28-4030	Sex 7. Age (In yrs 1	Yrs. If Und Month	er 1 Year If Under 24 Hrs S Deys Hours Min			nplace (State or Foreign untry) MD
	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
Director	MD. N/A	В	ALTIMORE				Y Yes 2□ No
al Dire	10e. Street and Number 5200 BOWLEYS	LANE, APT.		21206	10	lg. Citizen of What Cor USA	untry?
by Fune	11. Marital Stetus 1 Never Married 2 Married 3 Note A Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	if Yes, sp	edent of Hispanic Origin? (5 secify Cuban, Mexican, Puer 2XNo Specify:	Specify Yes or No- to Rican, etc.)	14. Raca - Amer Black, White Specify: W	
Completed	15. Decedent's E (Specify only highest gi Elementery/Secondery (0-12)		life. DO NOT	vork done during most of wo use retired)	orking 1	6b. Kind of Business/I	
	12TH 17. Father's Name (First, Middle, Las	41	HOMEMAI		me (First, Middle, M	OWN HOME	
To Be	HARRY HAMILTON				BETH DEL		
	19a. informant's Neme/Relationship BRIAN LINDSEY,			ss (Street and Number or A NBROOK RD.			
ary or other	20e. Method of Disposition 1	Removal from State	Place of Disposition (A cemetery, cremetory o EST LAWN	teme of rother piece) MEMORIAL 8	N	Oc. Location - City or MARYLAN	VILLE
for use as the butter transit as clar/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	· Class 1	Cardiol or es a consequence o	uyopathy estive hear			
detached for use	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	cause diven in Part I	23h Did tol	hacco use contribute	to the cause of death?
/ Phys	Tarti. Otto symiosic conditions	contributing to death out not re	solding in the underlying	Joans Green III att.			obably 4 Unknown
, page 2 should be detached for use. Completed by Physician/N					24a. Was ar perlorm	ned?	Were autopsy findings available prior to completion of cause of death?
Com					1□ Ye	s 2 liko	I □ Yes 2 □ No
B B	25. Was case referred to medical examiner?	Hospitel:		Other	eth (Check only one		
neral director, pag	1 Yes 2 No 27. Manner of Death	28e. Dete of injury (Month, Day Year)	28b. Time of Injury	28c. injury at Work?	Home 5 Reside	nca 6 Other (Spec w injury occurred	city)
edical Certification:	1 Accident	on Disco of lainer All	M nome, ferm, street, fact	1 ☐ Yes 2 ☐ No	281. Location (Str. City or Town	reet and Number or Ru , State)	iral Route Number,
etely filled		hysician: To the best of my kn miner: On the basis of examin and menner stated.					
Med	29b. Signature end title of certifier			9c. License number	29	9d. Date signed (Monti	h, Dey, Year)
7	Kety Khur	ma M.D.		21008	,	August 1	4, 2000
5	30. Name and address of person who 4940 EASTER	completed cause of deeth (ite	m 23a) (Type, Print) Baltmor	e Maryland	2121	4	
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		books			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Narpe (First, Middle, Last) 2. Data of Death ucs 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE (If not institution, give street and number) TOWSON If Under 1 Year Social Security Number 7. Age (In yrs. lest birthdey) Days Hours 224-36-2988 78 Yrs. irginia Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md **Baltimore** 1 ☐ Yas 2 ☑ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Sidewell Court 21221 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 Yes 2€ No Specify: White Specify: 3 □Widowad 4 □ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Cottege (1-4or 5+) Homemaker own home 4th 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Jesse Allen Kirby MAry Anna Christian 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard E. Lucas / son 2130 Ruffs Mill Road Belair Md. 21015 20b. Place of Disposition (Neme of cemetery, crametory or other pleca) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ➡ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Cemetery 8/17/2000 Baltimore Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only are cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in deeth) MONDA 6 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequenca of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Wes an eutopsy performed? 22 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical 26. Place of Deeth (Check only one) 1☐ Yes 2☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify)

Physician /Medical Examiner

important of Health as Important if Nam 27 is n any Injury or other

Physician

/Medical

Examiner

Director

or items 25s or 28s-f show

filed within 72 hours after

Mental ahould be

pu

Maryland 21215-0020

Baltimore,

Box 68760.

P.O.

Division of Vital Records,

the Medical Examiner must be notified

Director

Funeral

by

Completed

The law requires that the death certificate be execu the attending physician use as the page 2 should be detached been signed by this certificate hes or Attending Physician: after death.

Physician/Medical Examiner Medical Certification: To Be Completed by eral Director: After this certifical filled in by the funeral director, i

To the Hospital within 24 hours a To the Funeral D completely filled

State Registrar

9 31. Date file (190)

27. Mannar of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title

5 Pending investigation

6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print 32. Registrar's Signaru

29c. License number

Injury at Work?

1 Yes

2 No

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dey, Year)

281. Location (Streat end Number or Rural Routa Number, City or Town, Stete)

105

28d. Dascribe how injury occurred

21277

28b. Time of

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26229 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** Edith A. Leftin August 17, 2000 4:30 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Futurecare Cherrywood Health Care Reisterstown Baltimore Year | If Under 24 Hrs. Days | Hours | Min. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 8. Dete of Birth (Month, Day, Year) Birthpleca (Stete or Foreign Country) **Funeral** 10M 25F Months Days Yrs Director 217-20-7074 April 8, 1923 Maryland Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits mar be notined at Maryland Baltimore 1 Yes X2 No Director Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 909 Lindellen Avenue 21136 U.S.A. Completed by Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 14. Race - American Indien "natural", or frame 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental hygiens. Important: If Itam 27 is marked other than "natural; or Hemany injury or other traumatic event, the Medical Eventines once. Bieck, White, etc. 1 Never Married 2 Merried White 21215-0020 1 Yes 2 No Specify 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Operator Telephone Company Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumems) Howard Appeltofft Freda Schrepfer 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lynn Kochis (Niece) 10228 Harvet Fields Drive, Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta W Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 8/19/00 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, Maryland 21133 H.BC 23a. Part 1. Emer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical tmmediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Completed by Physician/Medical the Due to (or as e consequence of): for usa as P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. 24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? CERDIOUASCU this certificate has 1 secone 1 Yas 20100 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director. 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 -No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! 5 Pending investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 29e. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

State Registrar

DAMH 16 Rev 6/95

1 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and tifle of certifier

32. Registrar's Signature

Court Rd. Balt, mo

29c. License number

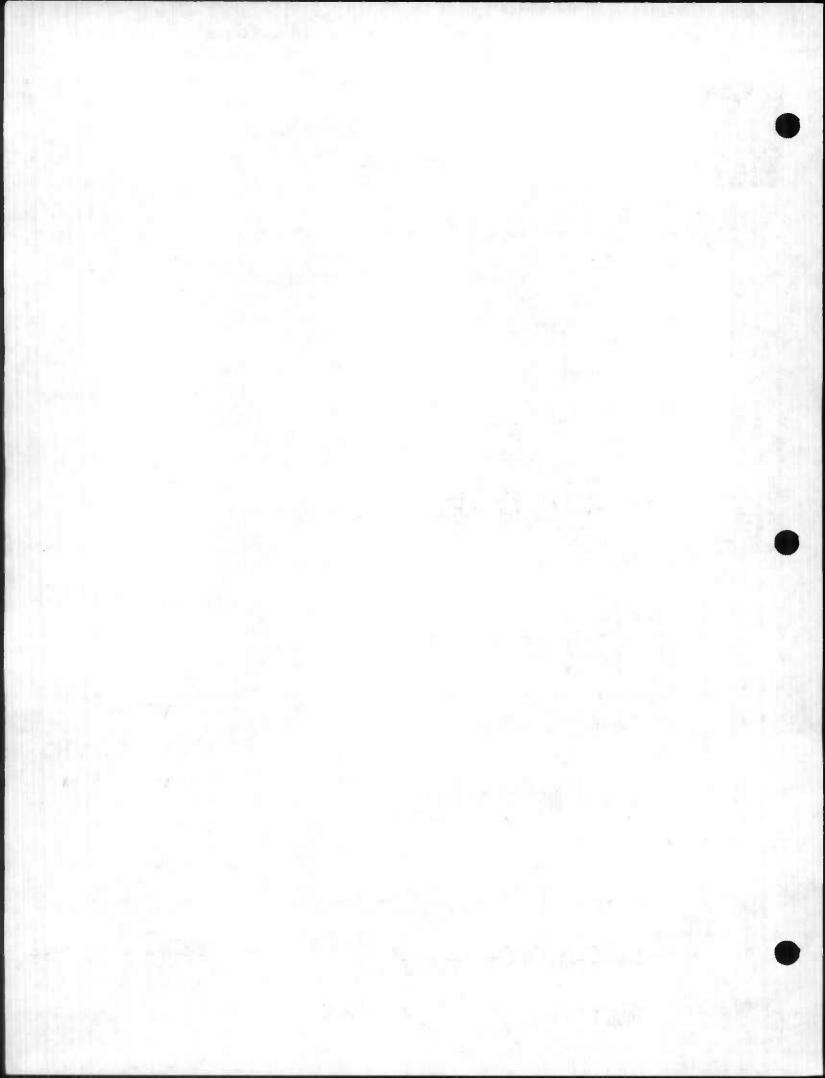
29d. Date signed (Month, Dey, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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_					Certifica	le oi	Dealli		Reg. No.		
5	Physician /Medical	1. Decedent's Neme (First, Middle, La NANCY DYER	LEONARD					2. Date of D		3. Time of D	
	Examiner	4e Facility Neme (II not institution, giv Saint Joseph	e street and number) Medical	Center	7.4			or Location of Dec	eth 4c. County	y of Death Baltimore	
	Funeral Director	5. Social Security Number 2 1 4 - 0 1 - 8 0 3 6	ex 7. Age ☐ M 2 ☐ F	(In yrs. last birtl 84 Y	rs. If Und Months	er 1 Year Deys		Min. 8. Date of E	Bay, 1916	9. Birthplace (State or Mary land	Foreign
Marvland	of show fled at tor	Usual Rasidanca of Decedant 10a. State 10b. County Maryland N/A		10c. City, Town Balti						t0d. Inside City	
with the	a or 28a-fre the notifie	10e. Street and Number 904 Bellemore Rd			10f. 2	ip Code	0		10g. Citizen of U.S.		
020 un attar death	ar, or tama 23a Examiner must by Funeral	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:				dispante Origin' en, Mexican, Po Specify:	? (Specify Yes or it uerto Rican, etc.)	Bla	ce - American Indien, ck, White, etc. y: White	
Baltimore, Maryland 21215-0020	ypera. Net the Medical of Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) Collega (1-4or 5		Decedent's Us (Give kind of v life. DO NOT CCULIV		pation during most of d) easure	working		Company	
/land	Mental Hyg riked other rific event, To Be C	17. Father's Name (First, Middle, Last, ALEXIUS ALOYSIUS						Name (First, Midd A MELANIA		пө)	
, Mary	and as ma	19a. Informant's Name/Ralationship (Mrs. Nancy Miller						altimore,			
imore Pages 1	ment or tant: If it lary or o	20e. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removel from State y) Entonoment		, cremetory of	other ple		Date 8/19/00		- City or Town, State m, Maryland	
Balt	Depart Import any inj ance	21. Signature of Funeral Service Licer	n. Kro	+	22. Name Mito			eld Fune		Inc.	
1	nysician Medical xaminer	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final diseasa or condition resulting in death)	PNEUMO	~		-	ig, outri as car	dac of respiratory	arrest,	Approximate Interval Betwoonset and Do	veen
ox 68760, certificate be executed	iding physician and isa as the bunal-fransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	C	Due to (or as a co							
. Bo	atten I for u							1		1	4.4.00.0
P.O.	hed by the attended for y Physicia	Part It. Other significant conditions of RECENT MYOCARDIA			tha underlying	cause gi	ven in Part I.		d tobacco use co	3 Probably 4 L	
Records,	200	ARTERIOSCLEROTIC	CARDIOVAS	CULAR DI	ISEASE			24a. We pe	as an autopsy rformed?	24b. Were autopsy fir aveilable prior to completion of ca of death?	0
E	page 2		100 2					10	Yes 2 No	1 □ Yes 2 1 1	No
Vita	is certificate director, pag To Be Co	25. Was case referred to medical examiner?	Hospital:	- AD 50/0	nations 201	Otl Otl	200:	Death (Check only		trans (Consider)	
Division of Vital or Attanding Physician:	fler th meral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Dey	y 28b. T		28c. I <i>n</i> ju Wo		-	e how injury occu		
Division of Attanding	within 24 hours after death. To the Funeral Director: After the completaly filled in by the tuneral Medical Certification:	3 Suicide 6 Could not b		ny - At homa, fan (Specify)	m, streat, facto	ory, offica		28f. Location City or T	(Street end Num Town, State)	ber or Rural Route Numb	ber,
Ne Hospitz	n 24 hours ve Funeral pletaly fille edical C	29a. Certifiar 12 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of and manner sta	examination and	death occurre Vor investigation	d at the ti	me, data and p opinion, daath o	laca, and due to the	na causa(s) and m e, date and place	annar as stated. , end due to tha cause(s))
J to th	To the comp	29b. Signature and title of certifier Beating	P. Ou	on M	1.D. 1		se number 492		29d. Date sign	ed (Month, Day, Year)	000
	18	30. Name and address of person fold BEATRIZ P. DIZ	completed cause of the	76 21 1	Type, Print) DSLER	DRI	VE TOW	ISON, MA	ARYLAND	21204	
	State	31. Date filed (Month, Dey, Year)	32. Registre	r's Signature	4 1	park	6				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 16:45 PM Ida Madeline Litton 2000 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours Min 1□M 2以F Yrs May 16,1917 83 PA 215-36-5957 Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 1 No Fulton Big Cove Tannery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 184 Big Cove Tannery Road 17212 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc.

1 ☐ Yes 2 No

Seamstress

20b. Placa of Disposition (Name of cemetery, crematory or other place)

Damaucus Cemetery

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

emminio

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

2 ER/Outpatient 3 DOA

28b. Time of fnjury

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Dulinguare

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify:

22. Name and Address of Facility
Grove Funeral Home, P.A.

Saltimore, Maryland 21215-0020 permit. Pages 1 and 2: Department of Health er Important: If itam 27 is any injury or other traughts. Physician /Medical Examiner

MADELINE

Physician

。/Medical

Examiner

10a. Stata

11. Marital Status

1 Never Married 2 Married

15. Decedent's Education (Specify only highast grade completed)

College (1-4or 5+)

3 Widowed 4 □ Divorced

Elementary/Secondery (0-12)

Lemuel Shives

20a. Method of Disposition

tmmediate Cause (Finat disease or condition resulting in deeth)

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

17. Father's Nama (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21 Bignatury of Funeral Burries Licenses

Madeline C.Booth/Daughter

1 N Burial 2 ☐ Cremation 3 ☐ Removal from State

Funeral

Director

or 28a-f show

234

or items

"natural".

other

filed within Hygiene.

1 and 2 should be fi Health end Mentel H am 27 is marked out

within 72 hours after

Director

Funeral

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Completed

Be

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other traumatic avant, the Medical Examiner must be notified at

To the Hospital within 24 hours a To the Funeral C completely filled State Registrar

DHMH 16 Ray 6/95

Division

Examiner the ettending physician and the for use as the burial-trans Physician/Medical signed by py 2 Completed pege 2 s Be 10 this Certification: death. after ò Hospital

edical (Check only one) 29b. Signature and title of cartifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.

1 Inpatient

28a. Date of Injury (Month, Day Year)

29c. Licensa number

28c. Injury at Work?

1 TYes 2 No

29d. Date signed (Month, Day, Year)

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

Hospitet:

5 Pending investigation

6 Could not be determined

un-12821-OAK Hil (AVE. HAGERSTOWN. MD WAHERD

31. Data filed (Month, Day, Year)

25. Was case referred to medical

1 Yes 2 PNo

27. Manner of Death

1 Matural

2 Accident

3 ☐ Suicida

29a. Certifier

4 Homicide

32. Registrar'a Signature doork

ORIGINAL

23b. Did tobacco use contribute to the cause of death?

Specify:

18. Mother'a Name (First, Middle, Maiden Surname)

Eva Pittman

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

141 W. Main St. Hancock, MD 21750-0368

3288 Tollgate Ridge RD Big Cove Tannery, PA 17212

16b. Kind of Bustness/Industry

White

Clothing Manufacture

20c. Location - City or Town, State

8/16/00 Big Cove Tannery, PA

1 Yea 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 ☐ Yes 2 1No 1 ☐ Yes 2 ☐ No

Approximete intervat Between Onset and Death

Week

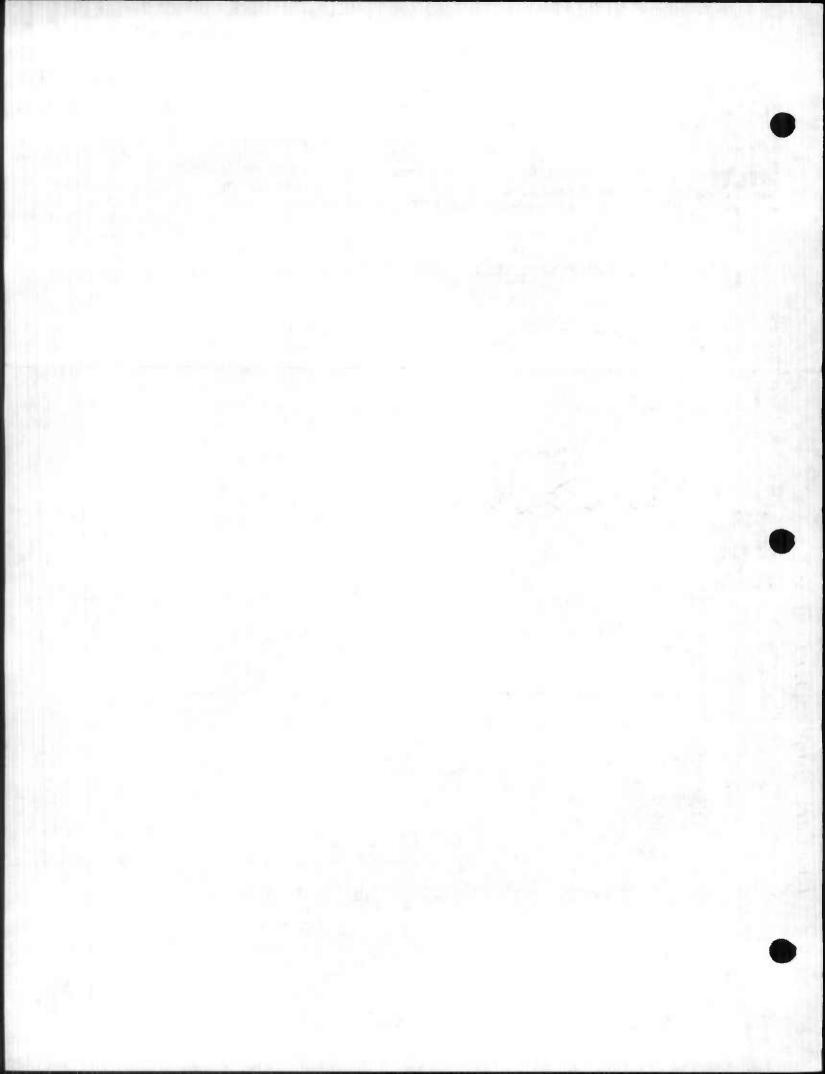
26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statad.



detached for use as the burial-transit permit. Pages 1, 2, 3 should

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page

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	4	y fil	thor
ů,	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within thus after death	INERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the fune	thin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	DING	After	death
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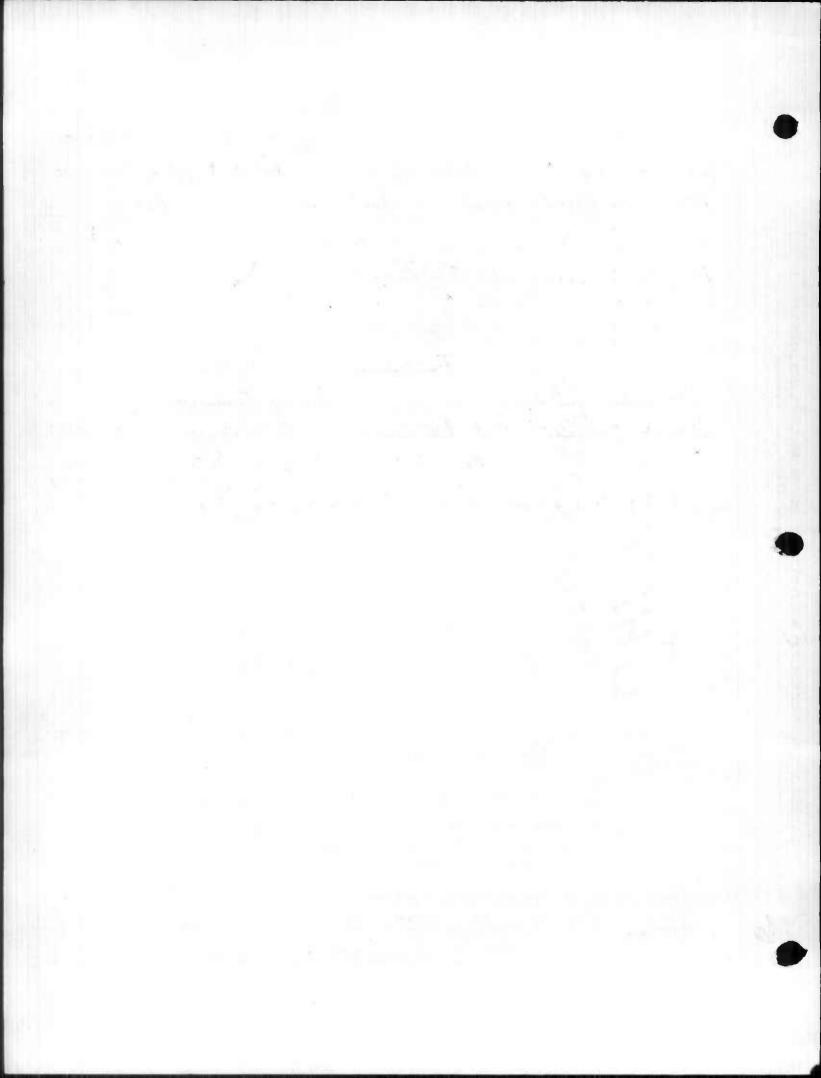
STATE 8/22/00 ys STATE OF MARYLAND / DEPARTMENT OF HEALTH AN REGISTRAR AMEND 1 per phys. G786 CERTIFICATE OF DEATH STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN Robert Cardozia McCoy 3. TIME OF DEATN VEAD AUGUST 2000 F UNDER 1 YEAR 8. SEX 7. DATE OF BIRTH (Month, Day, Year) WARCH 28 6. AGE (In yrs. last birthday IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 925 South Caroli NA
9c. COUNTY OF DEATH DAYS HOURS 1 M M 2 - F YRS. + Oliver Street 9b. CITY, TOWN OR LOCATION OF DEATH 1401 East DIRECTOR 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Himore Maryland
100. STREET AND NUMBER 1 X YES 2 NO FUNERAL B 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2/2 12, WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 KNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: BY 3 Wildowed 4 Divorced BE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working (Give kind of work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5+) TRACK MAN 18. MOTHER'S NAME (First, Mic notified at Baltimore, 2 DRINE FRIENO MD 21213 pe 20a. METNOD OF DISPOSITION
1 M Burial 2 Cremation 3 ... PLACE OF DISPOSITION (Name other place) Memori must 4 Donation 8 Other (Specify) 22. NAME AND ADDRESS OF FACILITY Magga Lean Gilmone MORTICION 5340 He: STER TOWN Baltimore, Mary land 212, 15 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENS POVSON Road MORI medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final SO MAGEN / CANCER

DUE TO (OR AS A GONSEQUENCE OF): the disease or condition month resulting in death) traumatic event, prior to burial. CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING OUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury shows any injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY 1 TYES ZYNO OF GEATH? 1 TES 2 DHO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) Hem 2 the State L **EXAMINER?** OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 8 C Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 2 NO 1 YES BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be determined COMPLETED 4 Nomicide Hem 29a. CERTIFIER 126 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. = 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: 11 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNEO (Month, Day, Year) D0053722 Aug 2000 2 OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print) PILLING GOOD SAMARITAN 31. DATE FILED (MANELING, 120) 8

32. REGISTRAR'S SIGNATURE

Zeneva

Dack



State of Maryland / Department of Health and Mental Hygiene 26233 Certificate of Death AMEND#20B PERF.H. G786 8-18-2000 JAB 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5,00 PM Meekins 4b. City, Town, or Location of Death Jane 2000 4a Facility Name (If not institution, give street and number) 4c. County of Death RANDALLSTOWN Baltimore County l-lospital Northwest Center If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. JUNE 15 1942

10f. Zip Code

1 Yes 2 No

21136

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

lest birthday)

10c. City, Town or Location

Yrs

REISTERSTOWN

7. Age (In yrs. 58

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates:

1 M ACKE

Funeral Director

Physician

/Medical

Examiner

5. Social Security Number

10b. County

215-40-2299

with the Maryland or Items 23a or 28a-f ahow the Medical Examiner must be notified at death "natural", al Hygiene.

filed within 72 hours after . Pages 1 and 2 should be fit iment of Heelth and Mental H tant: If item 27 is marked out other 6 permit. Page Depertment of Important: If any Injury

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

Physician /Medical Examiner

The law requires that the deeth certificate be executed ed by the attending physicien detached for use as the buna signed by 8 this certificate has or Attending Physician: After

efter deeth.

Director: Aff
d in by the fur filled in To the Hospital of within 24 hours of To the Funeral D completely filled is Medical

Examiner Be Completed by Physician/Medical

(Check only one)

29b. Signeture end title of certified

Usual Residence of Decedent 10a. Stete MD BALTIMORE Funeral Director 10e Street and Number 76 SHROPSHIRE COURT 11 Marital Status Completed by WILLIAM

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Sacondary (0-12)

College (1-4or 5+) BAKER 18. Mother's Neme (First, Middle, Maiden Sumeme) (UNKNOWN) 17. Father's Name (First, Middle, Last) ANNABELLE HADEL 19e. Informent's Neme/Relationship (Type, Print, 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4602 OWINGS RUN ROAD APT. 101 OWINGS MILLS, MD.21117 CAROLE MEEKINS/ DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Neme of 8/17/2000 cemetery, cremetory or other pleca) Buriai 2 ☐ Cremetion 3 ☐ Removel from State 8/16/00 4 ☐ Donation 5 ☐ Other (Specify) LAKEVIEW MEMORIAL PARK 21. Signature of Funeral Serviced los 22. Name and Address of Fecility SOL LEVINSON & BROS. INC eura 8900 REISTERSTOWN ROAD PIKESVILLE, MD. is thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Immediate Cause (Final disease or condition resulting in death) Intracerebral Hemorrhage Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of) Due to (or es e consequence of) Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24a. Was an autopsy performed? 1 ☐ Yes 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 Residence 8 □Other (Specify) 27. Mangler of Death 1 Di Natural 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) and menner steted. 29a. Certifier

29c. License number 28462

29d. Date signed (Month, Day, Year) August

2 No

9. Birthplace (State or Foreign MSountry)

10g. Citizen of What Country?

U.S.A.

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

ELDERSBURG, MD.

21208

24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

Approximate Interval Between Onset and Death

FOOD

14. Race - American Indian, Bleck, White, etc.

WHITE

10d. Inside City Limits

1 ☐ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Randallstown Maryland Nort Hospital Boston 31. Date filed (Month, Dey, Year) 32. Registrar's Signature Leviva

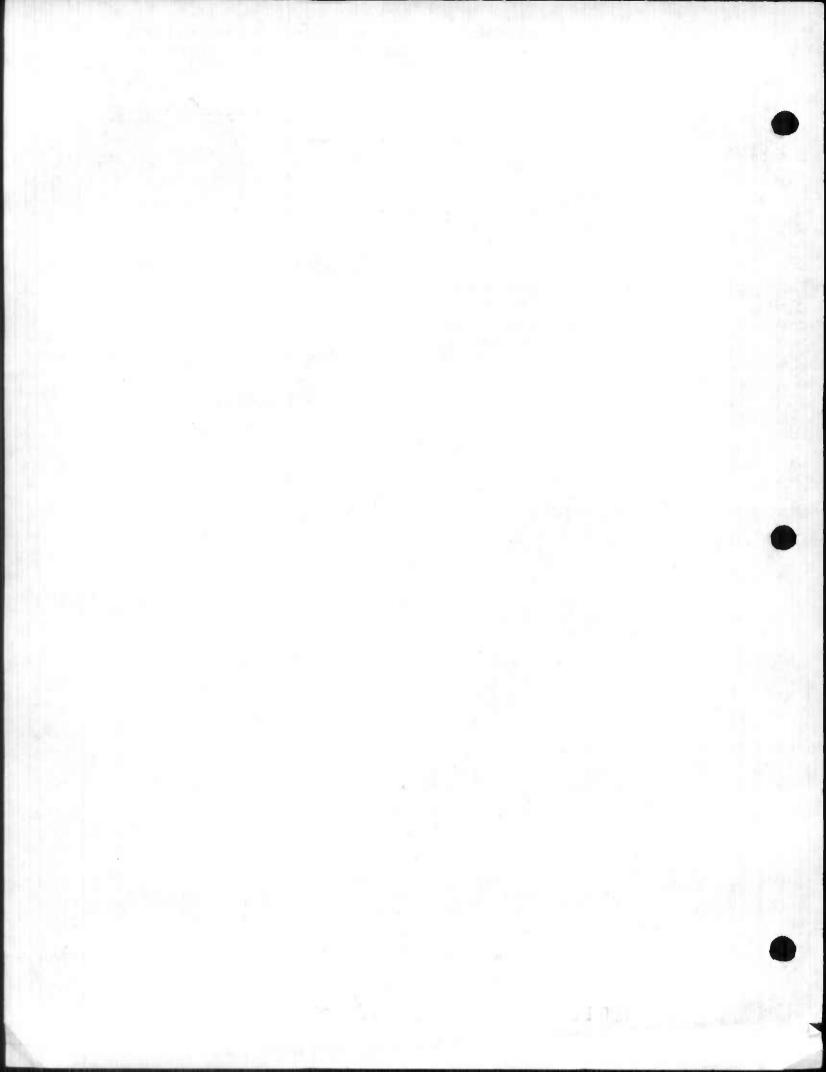
DHMH 16 Rav 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene

Cartificate of Death

	100 Lab. 100		Certific	cate of	Death		Reg. No.	10 26	231
alalan	1. Decedent's Name (First, Middla, Li	est)				2. Data of De Month	eath Day	Year 3. Tim	e of Deat
ysician Medical	Doris	V.	McQuaig	е		aucus	f 14 Z	2000 61	15
miner	4a Facility Nama (If not institution, gi	ve street and number)			4b. City, Town, or L	ocation of Deal	h 4c. County	of Death	
	Sinai Hospin	tal of BALt	10MOKET		Baltimo	RE City	/		
5		Sex 7. Age (In yrs	s. last birthday) If U	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9. Birthplaca (Sta Country)	ta or For
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	Usual Rasidance of Decedant	40- 6	. T					404 1-14	. 00. 11
_	10a. Stata 10b. County		City, Town or Location					10d. insid	
cto	Md. NA	E	Baltimor	е				יאַי	ſas 2□
Director	10e. Street and Number		10	Of. Zip Coda			10g. Citizen of	What Country?	
al	2107 Summit	Ave.	-	2123	7	100	USA		
Funeral	11. Marital Status	12. Was Dacedant Ever in I	U,S. 13. Was I	Dacedant of H	lispanic Origin? (Si an, Maxican, Puari	pecify Yas or No)- 14. Rac	ce - Americen Indiar	à,
	1 Nevar Married 2 Married	1 Yas 2 No				o moun, otc.)			
6	3 ☐ Widowed 4 ☼ Divorced	1 Yas 2 No If Yes, GiveX Yaar or Datas:	104	res 2 DXNo	Specify. Spec			Black	
3	15. Decedent's E	ducetion	16a. Decedant's	Usual Occup	pation	trin n	16b. Kind of B	usinass/Industry	
2	(Specify only highest gr Elementery/Secondary (0-12)	Collega (1-4or 5+)	lifa. DO N	OT usa retired	uring most of working				
Completed	12th Grade	B.A. Degree	City A	Audito					mor
	17. Fether's Name (First, Middla, Las				18. Mothar's Nan	na (First, Middle			
o Be	James	Robinson			Viol	et	Johns	son	
-	19e. fnforment's Name/Relationship	(Type Print)	19b Mailing Ad	idrass (Street	and Number or Ru	ıral Routa Numt	er. City or Town	State, Zip Coda)	
									22
	Lisa McQuaige 20a. Mathod of Disposition	20b.	Place of Disposition	IDITION (Nama of	end Rd.	, Balt Date		City or Town, State	220
	1 Surial 2 ☐ Cramation 3 [Removal from State	cametary, cramator	y or othar plac					
	4 ☐ Donation 5 ☐ Othar (Speci		ng Mem.	PK.	t	3/21/00	Randa	llstown	, M
	21. Signatura of Funeral Service Liqu	risee	22. Nar	ma and Addra	iss of Facility	Baltin	nore, M	ld. 212	02
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	23a/Part1. Enter the disease, or bon shock, or heart failure. Ustony	nnlications that causal the das						Approxi	mata
je l	disaasa or condition resulting in death)	a. Cluarum Due to	(or es e consequenc	ce of):				1	
Examiner	Sequentially list conditions, if any, leading to immadiata cause. Enter Undarrying Cause (Diseasa or injury	b. Dua to ((or as a consequanc	e of):					
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edical	rasulting In death) Last	Dua to (or as a consequance	e of):				1	
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Sic	Part II. Other significant conditions	contributing to death but not re	sulting in the underly	ying cause giv	ven in Part I.	23b. Did	tobacco uae co	ontribute to the cou	es of c
Physician/M						1	Y00 30 No	3 Probably	¢ □ Un
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8	No. of the second					24a. Was	an autopsy omed?	24b. Wara autoj availabla p	sy find
Completed						peri	Ollifoot	complation of death?	of cau
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Be	25. Was case rafarred to medicel examinar?	Hospitel:		Oth	26. Place of Dec				
10	1 Yes 2 No	12Unpatiant 2L	1	LI DUA	4 LI Nursing H		idance 6 Oth		
Certification:	1 Natural 5 ☐ Panding	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju		280. Dascribe	how injury occur	Irau	
á	2 Accident invastigation		N		Yes 2 No				
	3 Suicida 6 Could not I datarmined	28a. Place of Injury - At building, etc. (Spec	homa, farm, straat, fa	actory, office		28f. Location City or To	(Street and Numi wn, Stata)	ber or Rural Routa	Vumber
5									
Sal	29a. Certifier 1 Certifying P	hysician: To the best of my kn	nowledga, death occu	urred et the tir	me, data and place	, and due to the	cause(s) and m	enner as steted.	
edicai	(Check only 2 Medicai Exa	miner: On the basis of examin and mannar stated.	nation and/or investig	gation, in my o	ppinion, daath occu	rred at tha tima	, data and plece,	and due to the cau	sa(s)
Z	29b. Signature and title of partifies	//		29c. Licens	se number		29d. Date signe	ed (Month, Day, Ye	ir)
	1/1/	6		DC	0-000 of BA		A	A 14 7	00
	1	1 5 M		KEL) - 000) 4	rugun	11,60	10C
	30. Name and address of person who	completed cause of deeth (Ite	em 23a) (Type, Print)	1.1	1 1	11	0		
	CARIOS BAGIL	sy, MO Sino	al Hospi	tal.	ot ISAH	ti MORE	=		
e	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	lan	4				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) **Physician** /Medical Examiner 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 F Days Yrs. Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumetic avant, the Medical Examiner must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number ò 234 Funerai Pages 1 end 2 should be filed within 72 hours after death Was Decedent Ever Armed Forces? 1 Yas 2 No If Yes, Give Year or Dates: tems! in U,S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca -Black. Amarican Indian 11 Marital Status 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2 No Specify. p 3 ☐ Widowed 4 ☐ Divorced merican Completed 16a. Decedent's Usual Occupation (Giva kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ng most of working Department of Health and Mentel Hygiene. Important: If item 27 is marked other then any injury or other traumetic avant, the Me bloce. Elementary/Secondary (0-12) College 13-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Informent's Name/Relationship (Type, Print) 21218 MTU, MD 212.
Oc. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of 20c. Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Edneral Service License 21217 MO 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse of each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Dua to (or as a consequence of): Physician/Medical Examiner mentia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury and Dua to (or as a consequence of): signed by the ettending physician Box 68760 that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 10 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy parformed? Completed crative discidisease, spine 200 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient Other: 4 Nursing Homa 22 No 1 Yas 3□ DOA o Rasidence 6 □Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No after deeth. Director: / 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. 29a Cartifier 29b. Signatura and itted certifier 29d. Date signed (Month, Day, Year) 29c. License number eath (item 23a) (Type, Print) address of person who completed caus 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

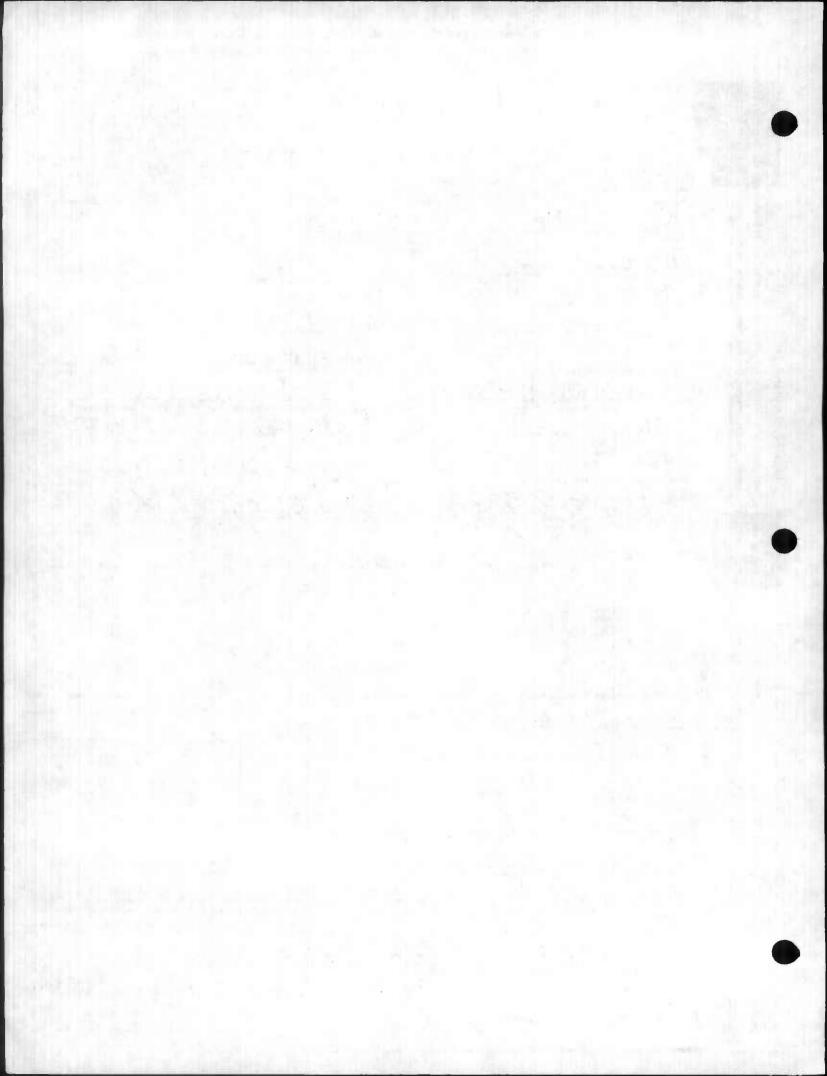
DHMH 16 Rev 6/95

Registrar

AUG

18

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26236 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Deeth 4a Facility Name (If not institution, give street and number) 4:30 AM 4b. City, Town, or Location of Death 4c. County of Deeth Greater Baltimore Medical Center Towson Baltimore 5. Social Sacurity Number If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) April 3,1942 6 Sax 7. Aga (In vrs. lest birthdev) 9. Birthplece (State or Foreign Months Days 1 M 2 XF Hours 218-42-5404 58 Maryland Usual Residence of Decedan 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Timonium 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Dodworth Court Apt 104 21093 USA 12. Was Decedant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Biack, White, etc. 1 ☐ Yes 2000 No If Yes, Give Year or Dates: 1X Navar Married 2 Married 1 Yes 2000 Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Nurse Hospital 12 18. Mother's Neme (First, Middle, Meiden Sumema) 17. Fether's Name (First, Middle, Last) Herbert Mc Kinley Helen M. Brown 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Susan Shugars 271 W. 31st Street, Baltimore, Maryland 21211 Sister 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 8/19/00 Parkville, Maryland Moreland Memorial Park 4 Donation 5 Other (Specify) 22. Name end Address of Facility 21. Signature Funeral Service Li Burgee-Henss-Seitz Funeral Home, Inc. 21211 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and failure. List only one cause on each line. Intervel Between Onset and Deeth tmmediate Cause (Final ensive disease or condition resulting in death) Due to (or es a consequence of): -d10 ana Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as e consequence of) Dua to (or es a consequence of) 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No 24b. Were eutopsy findings available prior to 24a. Was en autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) 2 No 1 Inpatient 2 DER/Outpatient 3 □ DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

Pages 1 and 2 should be filled within 72 hours after on ant of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or item inty or other traumatic event, the Medical Examment.

Department of important: If

Injury

buy

Maryland 21215-0020

altimore.

the Meryland

death

/Medical

Director

Funeral

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Completed

Be

and buriel-trar physician the use as 20 detached signed by I page 2 director.

Examiner Physician/Medical Aq Completed hes certificate Be 2 this funeral Certification: After

Box 68760 certificate be Division of Vital Records, P.O. Mospital or Attending
 124 hours efter death.
 Funeral Director: Afre in by

To the To the To the

State Registra

edical

29e. Certifier (Check only one)

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 25. Was cese referred to medical examiner 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Daries 31. Date tiled (Month, Dey, Yeer) AUG 1 8 2000

29b. Signature and title of certifian

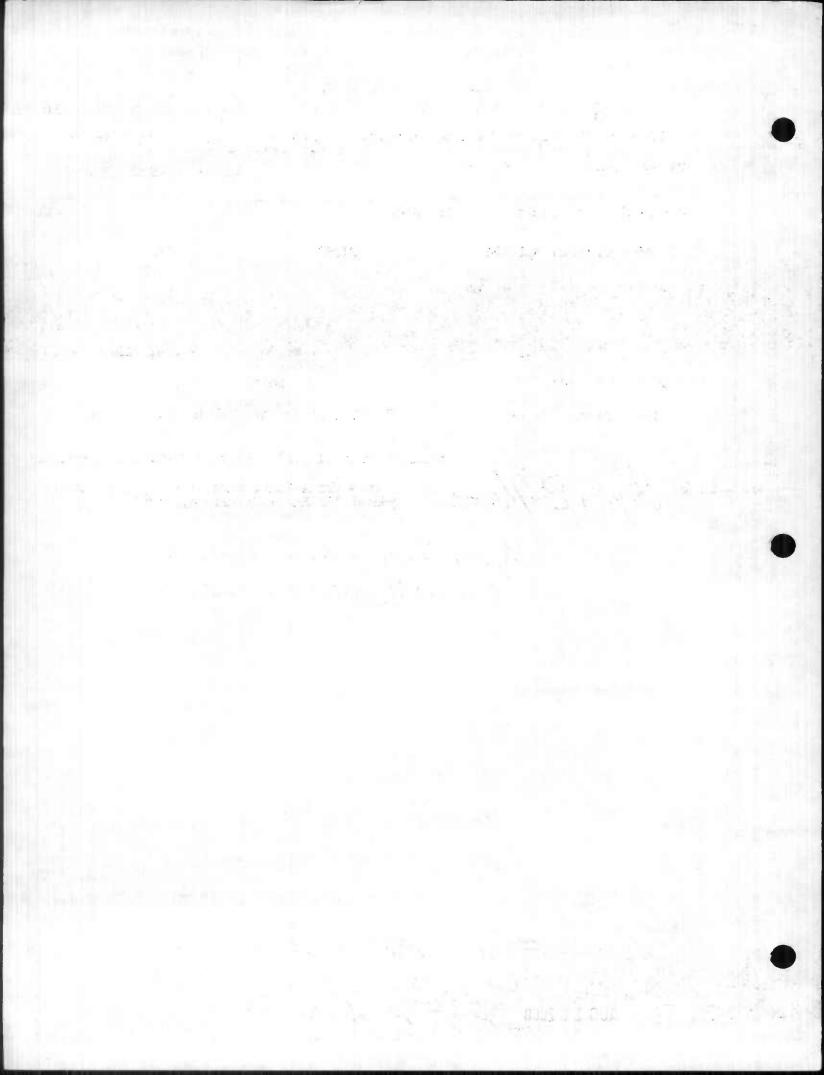
and address of person who completed cause of deeth (Item 23a) (Type, Print) ONNELL 32. Registrer's Signeture

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated.

29g. Licensa number

29d. Data signed (Month, Day, Year)



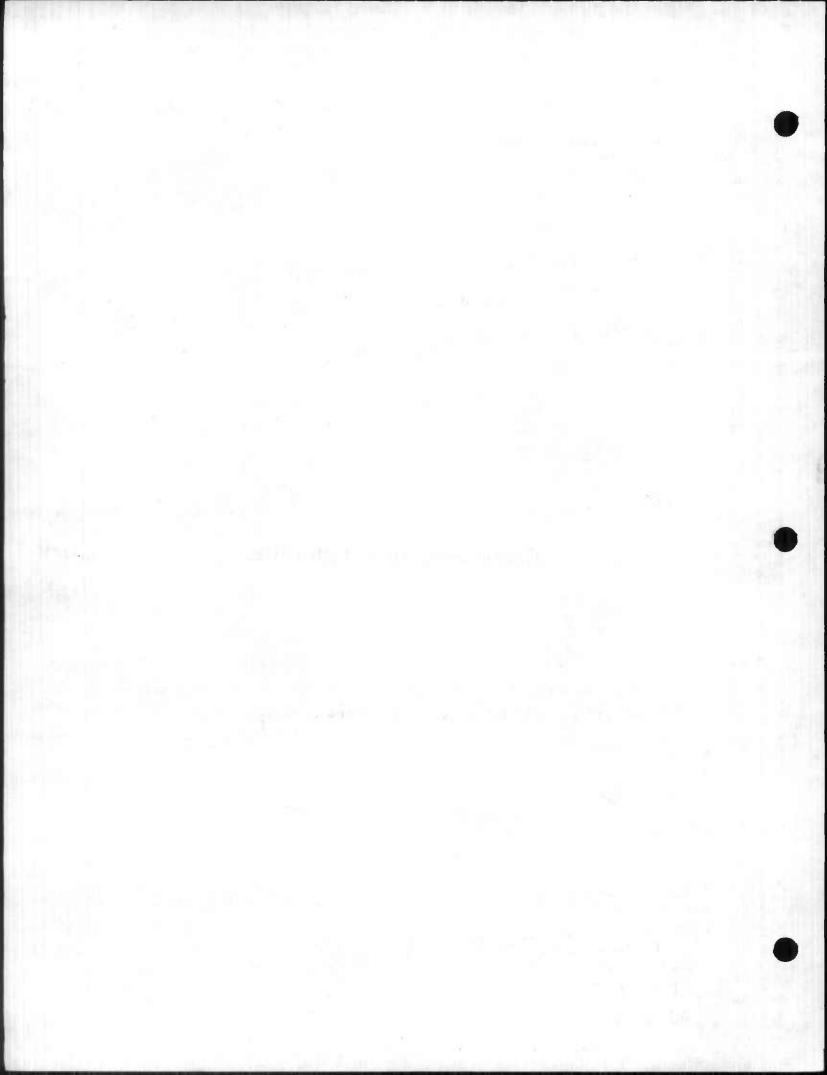
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 10:08 PM **Physician** 4b. City, Town, or Location of Death Mauerhan harles 13,2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore City Baltimore Reliabilatation and Extended Care 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Data of Birth Month, Day, Year) March 6 1909 Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 10 M 20 F 91 212 07 0241 Yrs. Baltimore, Maryland Director Usual Residence of Decedent the Maryland r 28a-f ahow 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r flams 23s or 2 4304 Necker Avenue 21236 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 14. Race - Amarican Indian. Pages 1 and 2 should be filed within 72 hours after dints of Health and Mentel Hyglens.
Instit I fem 27 le marked other than "natural", or frem iny or other traumatic event, make all all an in his yet of the traumatic event, make all all an in his his pages. Black, White, atc. 1 ☐ Never Married 2 X Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) NA Elementary/Secondary (0-12) Letter Carrier US Postal Service 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Charles Frederick Mauerhan Fdna Habn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Mauerhan (Wife) 4304 Necker Avenue Baltimore, Maryland 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State pemit. Page Department of Important: If any Injury or page. Gardens of Faith Cem. August 16 2000 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) heart Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Onknown 1 Yea 2 No Chronic renal insafficience Certification: To Be Completed by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of cause of death? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred To the Hospital or Attanding within 24 hours efter death. To the Funeral Director: Aftr 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ame and address-of person who completed cause of death (Item 23a) (Type, Print) OLUIN yary/and 31. Data filed (Month, Day, Year) 32. Registrar's Sjgnature State

DHMH 16 Rev 6/95

Registrar

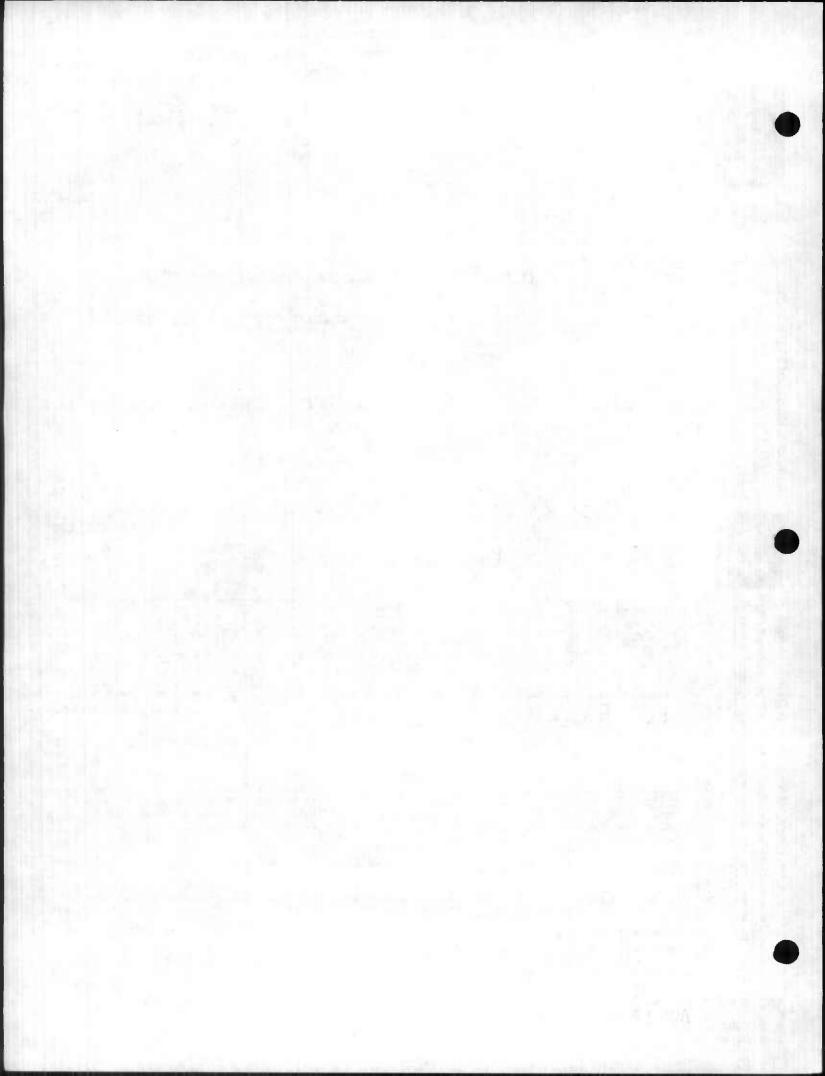
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State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death	Reg. No.	
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/Medica Examine	Ab City Town or	Location of Death 4c. County of Deat	
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Funeral Director	220-12-3071 1XXII 2 F 78 Yrs. Months Days Hours Min	Dec. 12, 1921 Vii	rginia
p .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits	
with the Marytan a or 28s-f show be notified at	Manual and David David		XX Yes 2□No
0 20 m	Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code	10g. Citizen of What Co	ountry?
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2 5 P	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business	/Industry
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yland with be it whental it white ever	Charles G. Myers Minni	e M. Duncan	
2 sho	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fi	Tural Route Number, City or Town, State, .	Zip Code)
	Hilda Whittington/Daughter 717 Appomattox Rd. Da	vidsonville, MD 210	35
orbe orbe	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or	
Baltimore, senti. Pape 1 a apartani di Has mportani: Il tiem i my injury or other files.	4 Donation 5 Other (Specify) Oak Grove Church Cemeter	y 2608 Aylor, Virgi	nia
Ball Department of the same in		ardesty Funeral Hom Annapolis, MD 2140	
Section 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.		Approximate interval Between
Physician	snock, or near tailure. List only one cause on each line.		Onset and Death
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that the detache	Renal Failure	1 Yes 2 No 3 P	Probably 4Q Unknow
Cords, P	Congertive Heart Failure	24a. Was an autopsy performed? 24b.	Were autopsy findings available prior to
Aec law has b	- yes rive lear larique		completion of cause of death?
al Relicate has controlled to page		1 ☐ Yes 2 Z(No	1 Yes 2 No
Vital I	25. Was case reterred to medical axaminer? Hospital:	eath (Check only one)	
F dis F	Inpatient 2 LI ER/Outpatient 3 LI DOA 4 LI Nursing	Home 5 Residence 6 Other (Spe	ecity)
After fune	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 38b. Time of Injury 48b. Time of Injury 48c. Injury at Injury 48c. Injury	28d. Describe how injury occurred	
DIVISION Of or Attending Physics of the death. Director: After this in by the funeral di	3 Suicide 4 Homicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or R City or Town, State)	lural Routa Number,
Hospita 24 hours Funeral tely filled			
within 7 to the comple	29b. Signature and little of certifier 29c. License number	29d. Date signed (Mon	th, Day, Year)
F 3 F 8		A.10 15	
	hung Kole Do HS5103	Trus 13	2000
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	111- 11-	///
	Kekky Kole, It South Greene Street, 1:	Hull I would Holder	ma (2120
State	ALIC 1 0 2000 6. Land 19		
Registra	AUG 1 8 2000 Sener & Sparks		



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			State of Marylai		tificate of			Reg. No.	0 21	5239		
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Fun Dire	_	5. Social Security Number 6. Security Number 214–18–9961A	On aulnux 7. Aga (In yrs.) 91		If Under 1 Yaar Months Days	Bathy If Under 24 Hrs. Hours Min.	8. Data of Bin (Month, Da			a (State or Foreign		
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th with the	al Director	10e. Street and Number 2009 Ruxton Road			10f. Zip Code 21216			10g. Citizen of V USA	What Country?			
within 72 hours and than matural, of the matural, of the matural and the matural and the manufactural and the manu	by Funeral	11. Merital Stetua 1 Nevar Married 2 Merried 3 Merried 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give Yeer or Detas:	11	/as Decedent of H Yas, specify Cub ☐ Yes 2 140	tispantc Origin? (S an, Maxican, Puart Specify:	pecify Yas or No Rican, atc.)		14. Raca - Amarican Indien, Bleck, White, atc. Specify: Black			
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Div To the Hospital or J within 24 hours after To the Funeral Dire	edical	29a. Certifiar 1 Certifying Physical (Check only one) 2 Medical Examination (Check only one)	nician: To the best of my knower: On the basis of examination and manner steted.	owiedge, death ation and/or inve	occurred at tha ti astigation, in my o	ma, data and placa opinion, death occu	, and dua to tha rred at tha tima,	causa(s) and ma data and placa,	anner as state and due to the	d. e cause(s)		
To the	Me	29b. Signature and title of cookier			29c. Licans	se number		29d. Data signe	d (Month, Day	(Year)		
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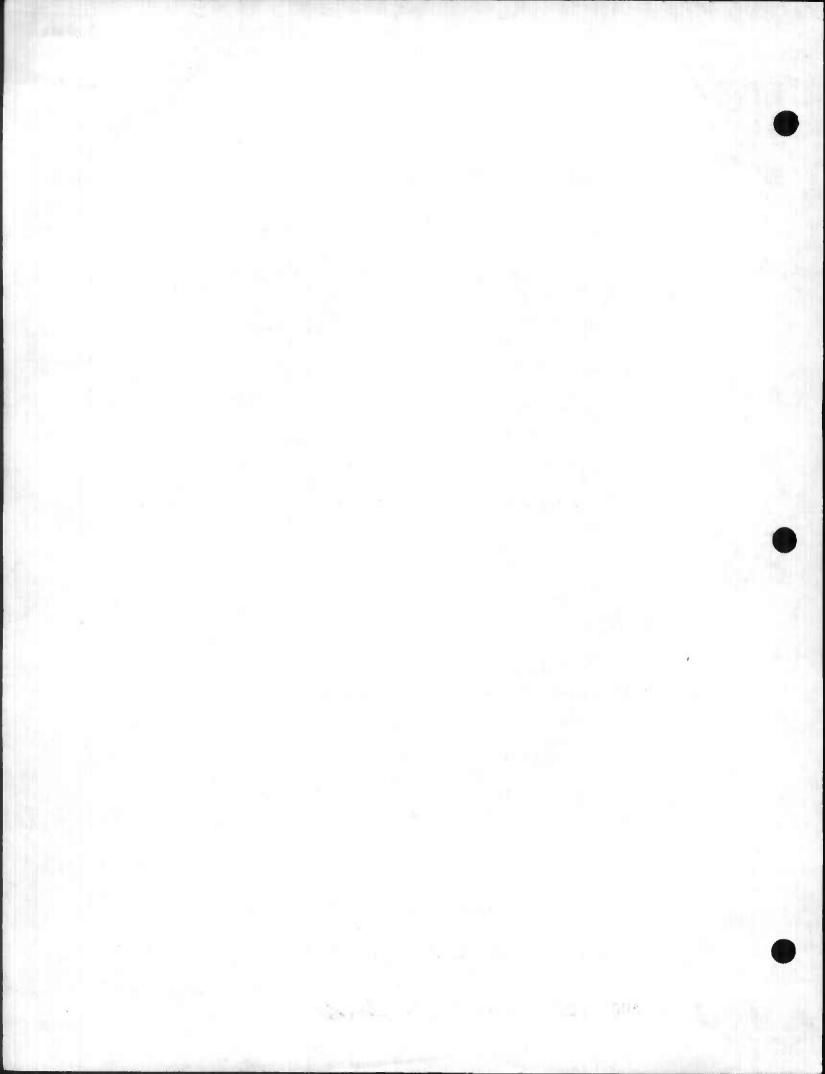
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MEND	ITEMS:	#	23	PARTI.	II.	27.	Certificate of Death	9-6-00 WRG U	6	0 2 41
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1. Decedent's Nama (First, Middle, Last					2. Date of De Month		3. Time of Dec				
	Outten				Month	Dav	Year				
4a Facility Nama (If not institution, giva	James A. Outten Augu										
	Location of Death		00 1815 p								
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5. Social Security Number 6. Se		In yrs. last birth	Months Day		8. Data of Bird (Month, De	ata of Birth Aonth, Dey, Year) 9. Birthplaca (State or F. Country)					
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	Z yıs.		CHEL	18. Mother's No	ame (First, Middle,						
Walter Outten				Maxi	ne Cro	SS					
		19b. I	Meiling Address (Stre				State, Zip Code)				
Susan Outten	wife										
20a. Method of Disposition		20b. Pleca of D	Disposition (Name of		Data 20c. Location - City or Town, Steta						
	Removal from Stete			rv I	Aug. 17	Baltin	nore				
21. Signature of Funeral Service Lemman 22. Nama end Address of Fecility											
Connelly Funeral Home Of Dundalk											
7110 Sollers Point Rd. 21222											
shock, or heart failure. List only o	ne cause on eechane.	, ,			Approximate Interval Betwee Onset and Dea						
tmmediate Cause (Finel	ACI	UTE NA	RCOTIC 1	INTOXICA	TION						
resulting in death)	8										
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Sequentially list conditions.	b. — Du	e to (or es a co	ensequenca of):								
Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of): Due to (or as a consequence of):											
Cause (Disease or Injury that initiated events Due to (or as a consequence of):											
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Part II. Other algnificant conditions co	ntributing to death but n	not resulting in t	the underlying cause	given in Part I.	23b. Dtd tobacco use contributs to the cause of dec						
CHRONIC PAIN					10	Yes 2 KNo	3 Probably 4 Uni				
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TEXTAS 2LINO	1 L Inpatient		Datient 3LI DUA	4 LI Nursing	7						
1 ☐Netural 5 ☐ Pending	(Month, Day Y	ear) For	md: V	Nork?	280. Describe						
Z D Accident		6:	00 M		201 Leasting						
4 Homicide	building, etc. ('Specify) ND: HO	n, street, factory, offi ME:	00	City or To	wn, State) 30 BALTIMO	05 SOUTHER RE CITY, M				
29a. Certifier 1☐ Certifying Phy	sician: To the best of m	ny knowledge,	deeth occurred et the	tima, date end ple	ca, end due to the	cause(s) and ma	anner as stated.				
(Check only 2 Medical Exami	ner: On the besia of ex end menner steted	caminetion end/ d.	or investigation, in m	y opinion, deeth oc	curred et the time,	date end placa,	end due to the ceuse(s)				
29b. Signeture and title of certifier	29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 16, 2000										
	Usuel Residence of Decedent 10a. Stete 10b. County Md. N/A 10e. Street and Number 3605 Southern A 11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementery/Secondery (0-12) 12 yrs. 17. Father's Neme (First, Middle, Last) Walter Outten 19e. Informent's Neme/Relationship (7) Susan Outten 20a. Method of Disposition 1 Burial 2 N Cramation 3 Factor of the County of t	Usuel Residence of Decedent 10a. Stete 10b. County Md. N/A 10e. Street and Number 3605 Southern Ave. 11. Meritel Stetus 1	Sequentially list conditions, if any, leading in death) Last CHRONIC PAIN Loc. City, Town Loc. City,	Usual Residence of Decodent	Usual Residence of Decadent 10a. Stete 10b. County Md N / A Baltimore 10c. City, Town or Location Md N / A Baltimore 10b. Steet and Number 36 05 Southern Ave. 21214 11. Mentel Stetus 12. Was Decadent Ever in U.S. Armed Forces? 17 8c. 2 No 18 2 No	Usual Residence of Decedent Use. Street and Number Use. Street and Number of Number Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street and Number or Fuer Route Number Use. Intermediate Use. Street Route Route Route Number Use. Intermediate Use. Street Route	Topic Topi				

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State of Maryland / Department of Health and Mental Hygiene 26241 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death PINKET ERNON 5:19A1 rigust 15 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death HOSPITAL BALTIHORE MEMORIAL If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) Months Min Deys Hours 16,1936 MARYLAND 10c. City, Town or Location 10d. Inside City Limits LE Yes 2 □ No 10g. Citizen of What Country?

21223

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

303 N. CAREYST.

ZION CEMETERY

Name and Address of Facility H. BROW 2140 N. FULTON AVE

Plece of Disposition (Name of cametery, cremetery or other plece)

with the Meryland 28a-f show troumetic event, the Medical Examiner must be notified at 23a or 2 filed within 72 hours after death Herne 6 Maryland 21215-0020 "nature!" Il Hygiene. n and Mental i Peges 1 and 2 should be permit, Peges 1 and 2 Department of Health a Important: If Item 27 ie eny injury or other treu page. Baltimore,

Physician

/Medical

Examiner

Funeral

Director

UNION

214-34-4202 Usuel Residence of Decedent

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondery (0-12)

EDWARD

20a. Method of Disposition

+HGRADE

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donetion 5 ☐ Other (Specify)

VORKER

1 Burial 2 ☐ Cremation 3 ☐ Removal from Stete

17. Father's Neme (First, Middle, Last)

10b. County

15. Decedent's Education (Specify only highest grede completed)

AREY

DAUGHTEL

22 Part 1. Eper the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, such as cardiec or respirelory effect, and the deeth of dying, and the deeth of dying, and the deeth of dying are respirely effect.

Due to (or as e consequenca of):

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Due to (or es a consequence of)

12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes:

College (1-4or 5+)

5. Social Security Number

10a, Stete

MARYLAND 10e. Street and Number

11. Marital Status

Funeral Director

Àq

To Be Completed

Physician /Medical Examiner

The law requires that the death certificate be executed

5

After this certificate has

or Attending Physician:

Box 68760.

P.O. 1

of Vital Records,

Division

Physician/Medical Examiner use as the buriel-transit

Medical Certification: To Be Completed by

director, page 2 should be detached filled in by

State Registrar

Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting In death) Last

1 Yes 2 No

29e. Certifier

Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical axeminer?

27. Manner of Deeth 1 Netural 2 Accident 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide

1 Inpatient

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 28d. Describe how Injury occurred 1 Yes 2 No

26. Plece of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) end menner stated.

22 No

29b. Signeture end title of certifier

FEEN

29d. Date signed (Month, Day, Year) DANERSTY BALTO, PARKWAY, MD 21218

14. Race - American Indian, Bleck, White, etc.

DOUGLASS

MD. 21223

Home

MD. 2121 Approximate Interval Between Onset end Death

16b. Kind of Business/Industry

20c. Location City or Town, Stete

JR. FUNERAL

23b. Did tobacco use contributa to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yee 2 No

24e. Was an autopsy performed?

1 Yes

Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

HOTEL

BALTIHORE

18. Mother's Neme (First, Middle, Meiden Sumeme)

Dete

19b. Mailing Address (Street and Number or Rurel/Route Number, City or Town, State, Zip Code)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) HOSPITAL, DEPT. INION MEMORY

Hospitel:

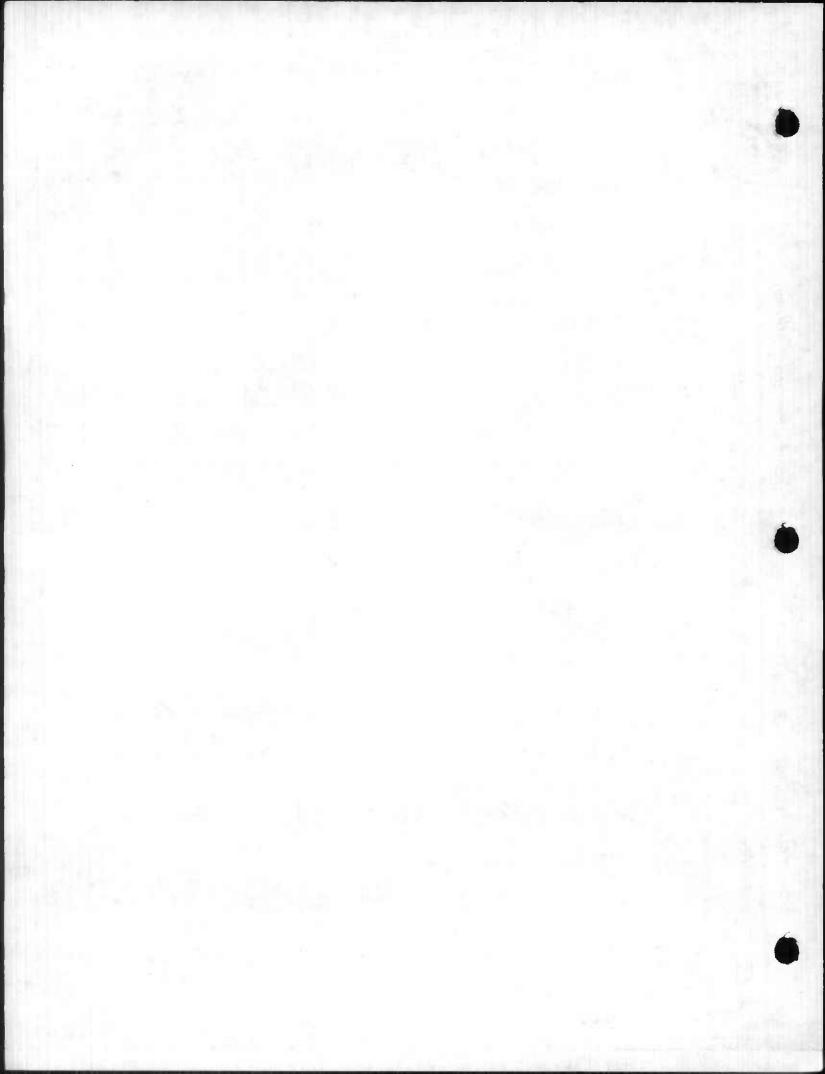
31. Dete filed (Month, Dey, Year) 32. Registrar's Signature **AUG 18**

29c. License number

DHMH 16 Rev 6/95

within 24 hours a Hospital

completely



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner If Under 1 Year 9. Birthplace (State or Foreign Country) last birthday) **Funeral** 1 M 2 K Days Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, 10d. fnside City Limits ital Hygiene. Id other then "natural", or items 23a or 28a-f ahow event, the Hedisal Examiner must be profited at 1 Ves 2 □ No Funeral Director 10g. Citizen of What Country? Street and Number 10f. Zip Code filed within 72 hours after deeth . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - Was Decedent of Hispanic Orlgin? (Specify Yes or No ff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) American Indian. 11. Marital Status 12 White, etc. Black. 1 Never Married 2 Married recar Baltimore, Maryland 21215-0020 1 Yes 20 No Specify by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumeme) parmit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Dices. 17. Father's Name (First, Middle, Last) 10 19a. Informant's Name/Relationship (Type, Print) S pouls 19b/ Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mne, MD2120 Jurmar 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 1500 roves-4 Donation 5 Other (Specify) 22. Name and Address of Facility mor 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARDIAL Examiner Due to (or as a consequence of) Physician/Medical Examiner HYPERTEMIAM Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DIABRITES Box 68760 Due to (or as a consequence of): the Part fl. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3□ Probably 4☑ Unknown signed by I 1 | Yee 2 | No Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of ceuse ot death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completaly filled in by the funeral director; p 25. Was cese referred to medicel examiner? 28. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Netural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

State Registrar

4510 Liberty 31. Date filed (Month, Day, Year) AUG 1 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

deshts

29b. Signature and title of certifie

32. Registrar's Signature outs

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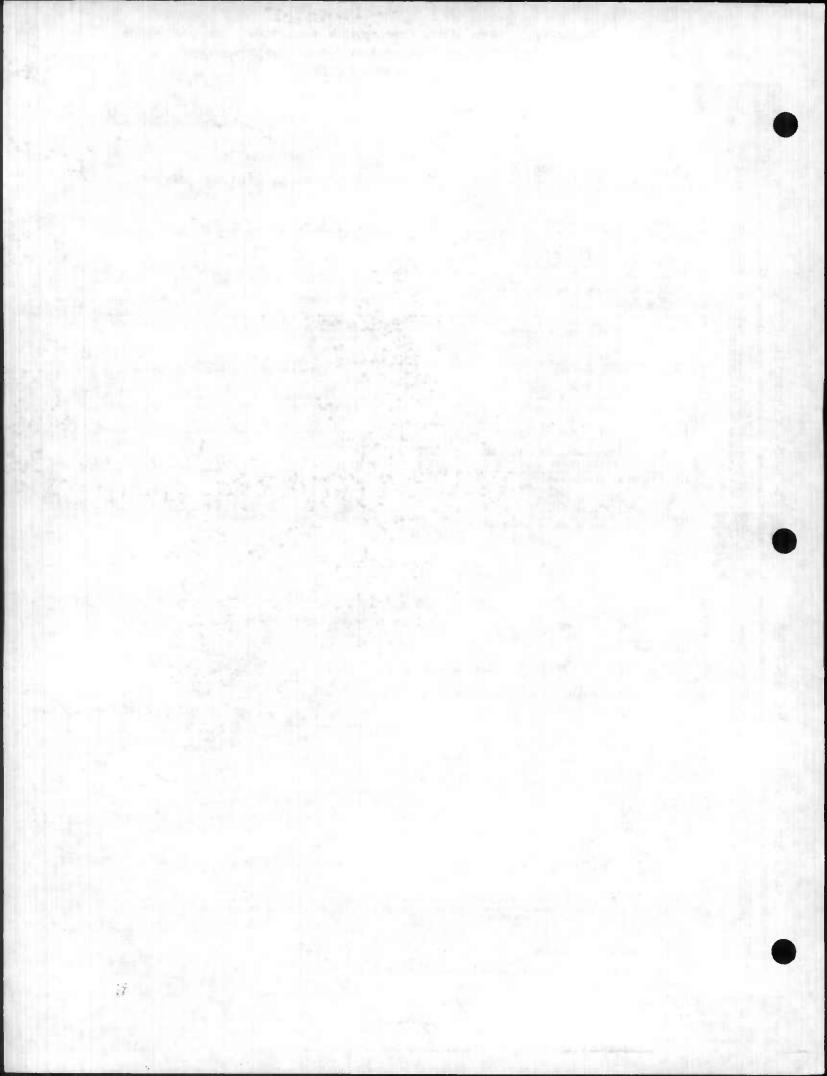
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Data

29c. License number

29d. Date signed (Month, Dev. Year)

16,200)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Des Yeer Mary Barbara Peterka August 12, 2000 10:30pm 4a Facility Neme (tf not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ASBURY HOME Montgomery County Gaithersburg If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 7. Age (tn vrs. last birthday) Birthplace (State or Foreign Country) Days Months 1□M 210 F 218-01-6259 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery County Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Russell Avenue, Apt 607 20877 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Federal 2 yrs Internal Revenue Serv. Secretary 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Suchanek Barbara Vlna Vincent 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, Stete, Zip Code) 20904 19a. Informent's Name/Relationship (Type, Print) Janet E. Scaggs (Niece) 15133 Middlegate Road, Silver Spring, Maryland 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/23/2000 Baltimore, Maryland Holy Redeemer Cemetery 21. Signati Funeral Service 22. Name and Address of Fecility Martin D. Auson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately 10116. Approximately 10116. Approximately 10116. Approximately 10116. Approximately 10116. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) MYOCARDIAL INFARCTION Minutes Due to (or as a consequence ot) Years HYPERTENSIVE HEART DISEASE Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as e consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Depression, Arthritis, Gastro-esophageal 24b. Were autopsy findings evaileble prior to completion of cause of death? 24a. Wes an autopsy performed? Osteoporosis 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medicat axaminer? 26. Place of Death (Check only one)

Physician /Medical Examiner

Department of Important: If any injury or pace.

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23s or 28s-f show Examiner must be notified at

"natural", or Items 23s

Pages 1 and 2 should be filed within 72 hours after neat of Heelih and Mental thyllene.
nt: if item 27 is marked other than "natural", or the rry or other traumate avent, the Mantal

Directo

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Completed

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death

21215-0020

Baltimore, Maryland

Box 68760

P.O.

Records,

Division of Vital

ician and burial-transit The law requires that the deeth certificate be assecuted 080 this

Physician/Medical þ Completed Be Certification: To 27. Manner of Death

edical

Examiner

or Attending Physician: 24 hours after death. Funeral Director: A filled in by Hospital

within 2

94

State

DHMH 16 Ray 6/95

completely 29b. Signature and fitle of certifier Purcelle Callatar Lyon mo

1□ Yes 2√ No

1 Neturet
2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only

1 | Inpatient 2 | ER/Outpatient 3 | DOA

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

29c. License number 041794

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) August 15, 2000

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Hospitat:

5 Pending investigation

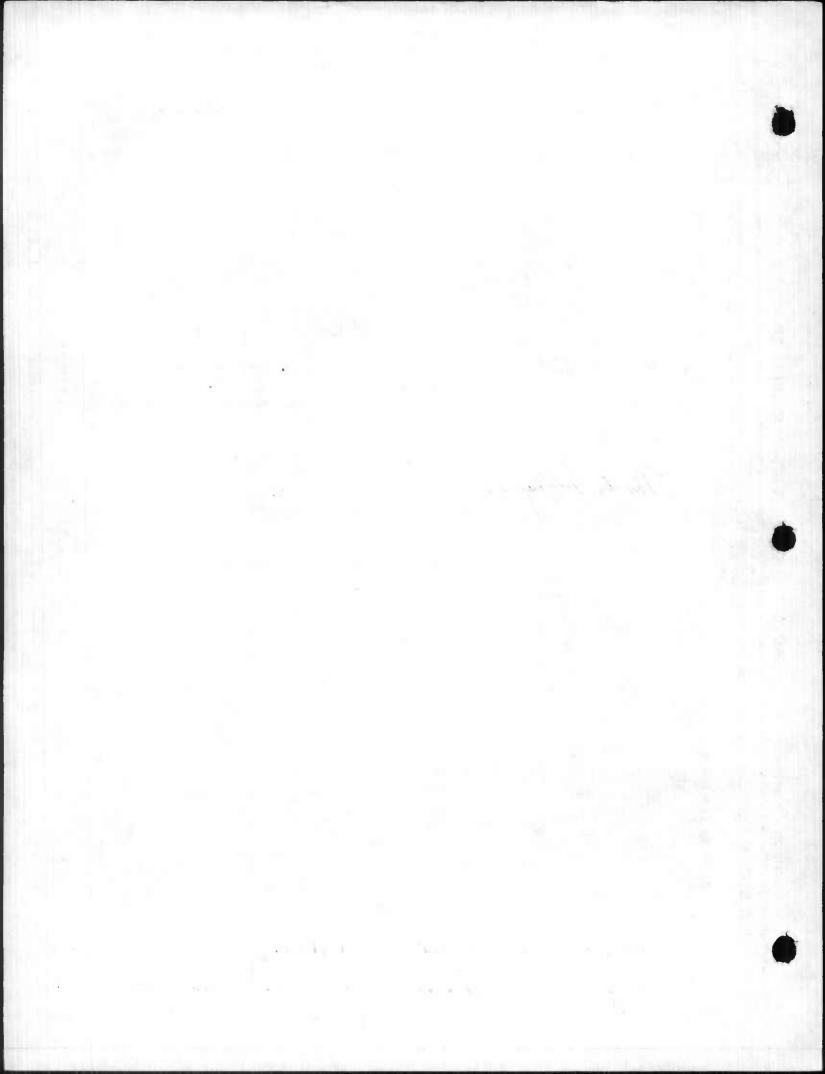
6 Could not be determined

28a. Date of Injury (Month, Day Year)

Priscilla Callahan-Lyon, M.D., 911 Russell_Ave., Gaithersburg, MD 20879

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Pennington August 17 2000 1:55 PM Martin /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Avenue Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 22 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 10 M 20 F 1926 Hours 73 Director 236-34-3636 Aug. **Usual Residence of Decedent** flied within 72 hours effer deeth with the Mendend Hyglene. ther than "neturel", or items 23s or 28s-1 show 10b. County 10c. City, Town or Location 10d. Inside City Limits me 23a or 28a-f short Director 1 Yes 2 No Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. of America 21222 11 Maryland Avenue Funeral Race - American Indian, Black, White, etc. r than "naturel", or items the Medical Examiner on 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Lieutenant Fire Fighter Fire Dapartment i. Peges 1 and 2 should be filled w tment of Heelth and Mental Hygler tant: If Item 27 Is marked other th jury or other treumatic event, to aitlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 2 Pennington Dorothy Harvey Homer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophia Pennington (Wife) 11 Maryland Avenue Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 1 Burial 2 ☐ Cremation 3 ☐ Removal from State pemit. Pege Department of Important: If eny injury or page. Eastpoint, Maryland Oak Lawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licery 22. Name and Address of Facility W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Baltimor 1005 Dundalk Ave. Baltimore, Md. 21224 Approximate Interval Between Onset and Death **Physician** 5 months Cancer /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner or Attending Physicien: The lew requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 20 087 Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? bronic Obstractive pulmonary 1 Yes 2□ No 2 3 Probably 4 Unknown bengis be del Be Completed by 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Conjetive Heart Falline completion of cause of death? P. . Velvular Hourt Disease this certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4□ Nursing Home 5♥ Residence 6 □ Other (Specify) Certification: To 1 Yes 2 No : After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation To the Hospital or Attending within 24 hours effect death. To the Funeral Director: Afte completely filled in by the function. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15: Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

20 and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif Mur, hs 1)40609 August 18, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

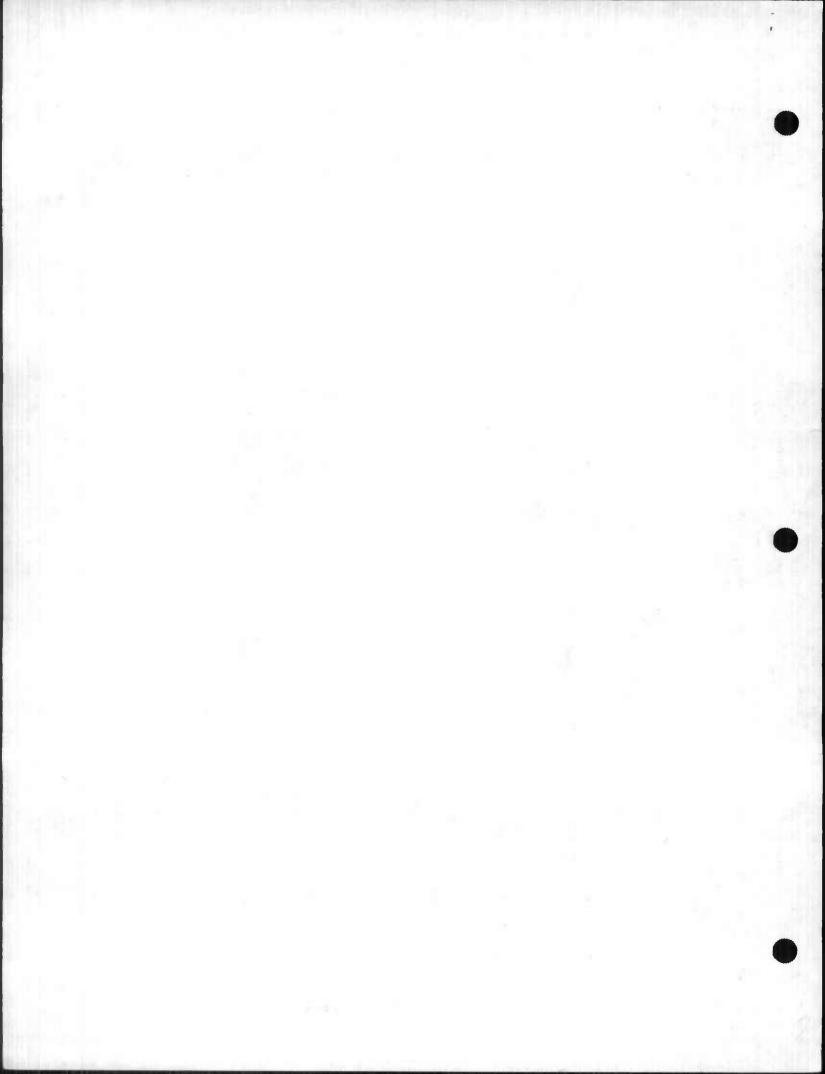
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32 Registrar's Signatur

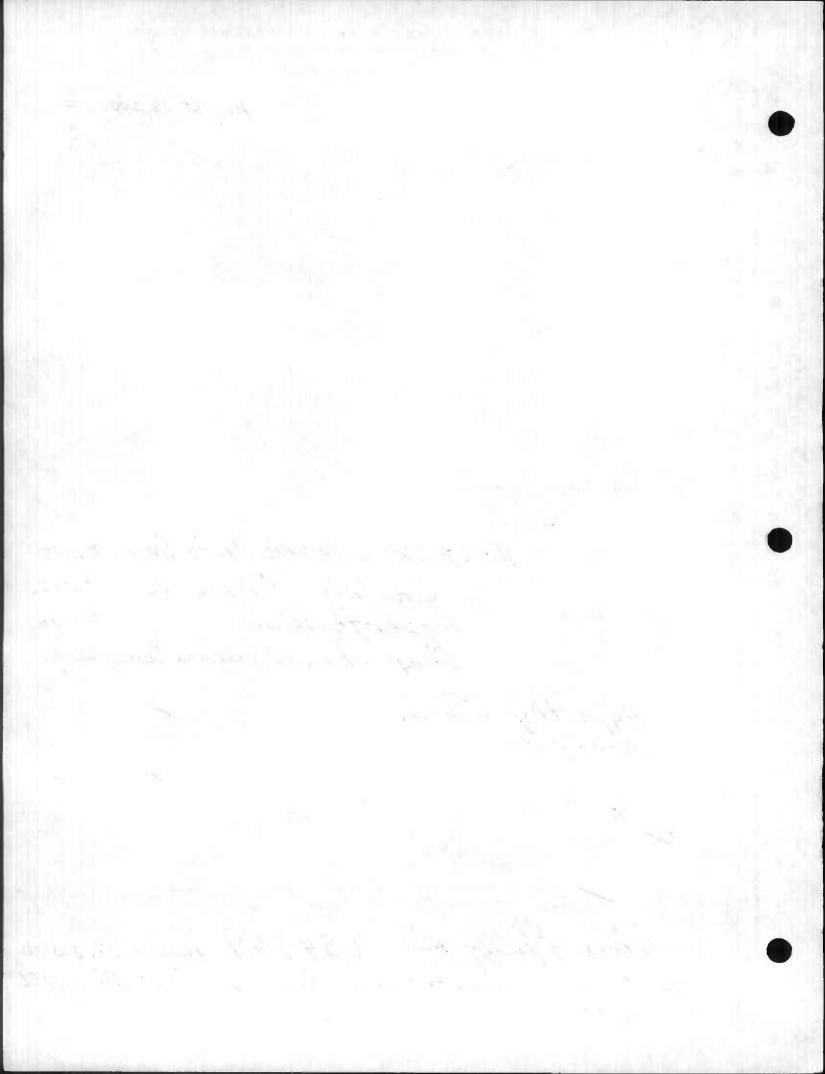


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		Certific	ate of Death	R	eg. No.	10 6	0243					
				2. Dete of Deel			Tima of Death					
CHARLES	FOWEL			0	14	2000	1245PM					
					4c. County	of Deeth						
		7 77 77				0.00						
243-20-1606				n. (Month, Day	Year)	9. Birthplece Country)	(State or Foreign					
10a. Stete 10b. County	10c. Ci	ty, Town or Location				10d. 1	Inside City Limits					
MD	В	ALTIMORE					Yes 2 No					
	ST			1								
11. Meritei Status	12. Wes Decedent Ever in U	.S. 13. Wes De	cedent of Hispanic Origin?	(Specify Yes or No-	14. Rec	e - Americen I	ndien,					
1 Never Merried 2 Merried 3 Widowed 4 Divorced	1X Yes 2 No	1 \(\tau \)		erto Hicen, etc.)			W.					
15. Decedent's E	ducetion	16a Decedent's I	suel Occupetion		16b. Kind of Bu							
		(Give kind of life. DO NO	work done during most of w Tuse retired)	vorking	CURTIS	BAY						
12	College (1-401 5+)	FORK LI	FT OPERATO	R	ORDNAN	ICE DE	PT.					
	1)		18. Mother's N	leme (First, Middle, I	Maiden Sumam	re)						
UNKNOWN			GEORG	GIANA PO	WELL							
19e. Informent's Neme/Reletionship	(Type, Print)	19b. Meiling Addr	ess (Street and Number or	Rurel Route Number	, City or Town,	State, Zip Coo	de)					
GERTRUDE POWEI												
20e. Method of Disposition	//	Plece of Disposition (cemetery, crematory	Neme of or other place)	Dete	20c. Location -	City or Town,	Stete					
	ity) / BAI	LTIMORE :	NATL. CEM 8	3-18-00	BALTIM	ORE M	D					
21. Signature of Furnital Service Licensee EUGENE WALKER 22. Name and Address of FecilityESTEP BROS. FUNERA												
1300 EUTAW PLACE BALTO. MD 21217												
23a. Part 1. Enter the disease, or con shook, general failure. Ciet gen	relications that caused the cee	th. Do not enter the r	node of dying, such es cerd	iac or respiretory err	est,	Ap	proximete ervel Between					
/ /	V /					On	set end Deeth					
Immediate Cause (Finel disease or condition resulting in death) e. CONGESTIVE HEART FAILURE												
Due to (or es e consequence of): CHW NC OBST NUCTIVE WAS Die to (or es e consequence of): If eny, leeding to immediate cause. Enter linetarying. Due to (or es e consequence of):												
	DISEA	EASE										
Sequentially list conditions,												
ceuse. Enter Underlying Ceuse (Diseese or Injury	C											
thet initieted events resulting in death) Last	TIS Due to for each consequence of):											
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Pert II. Other significant conditions	contributing to deeth but not res	sulting in the underlying		Part of the second								
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						24b. Were	eutopsy findings ole prior to					
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				1 D Y	es 2 No	1 D Y	s 218 No					
25. Wes cese referred to medical			26 Plece of E				,					
examiner? 1 Yes 2 No	Hospitel: 1 Inpatient 2	ER/Outpatient 3				er (Specify)	HYSICIANS					
27. Menner of Death		28b. Time of					FFICE					
		Injury M	1 Yes 2 No									
determine	286. Piece of injury - At fi	ome, farm, street, fac	etory, office			er or Rural Ro	oute Number,					
4 Homicide	building, etc. (Special	ry)		City of You	n, State)							
(Check only 2 Madicat Exa	minsr: On the basis of examine end menner steted.	endor investige	lion, in my opinion, deeth od		4- 27 11-4-1		A CHARLES					
29b. Signeture and title of certifier			29c. License number									
V/4.\ \	1 1	-	DZG 071		0/14/	2000	7					
MUUL					1 1 1	_						
30. Neme end eddress of person who	completed cause of deeth (Itel	m 23a) (Type, Print)	10/1	1 1 .	1	-1.	A 2 4a					
30. Name and address of person who	completed cause of deeth (Iter	m 23a) (Type, Print) N. EU7/	tw. 57 #	305 BAU	TIMON	EM	02/20/					
	4e Facility Neme (It not institution, gt 821 N EUTAW 5. Sociel Security Number 6. 243-20-1606 Usuel Residence of Decedent 10a. Stete 10b. County MD 10e. Street and Number 911 ALLENDALE 11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gt Elementery/Secondary (0-12) 12 17. Fether's Neme (First, Middle, Las UNKNOWN 19e. Informent's Neme/Reletionship GERTRUDE POWEI 20e. Method of Disposition 1 Met	4e Facility Neme (If not institution, give street and number) 821 N EUTAW ST. SUITE 3 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. 243-20-1606 1 M 2 F 78 Usual Residence of Decedent 10a. Stete 10b. County MD 10c. County MD 10c. Street and Number 911 ALLENDALE ST. 11. Merital Status 1 Never Merried 2 Merried 3 Merried 4 Merried 5 Merried 5 Merried 5 Merried 5 Merried 5 Merried 6	1. Decedent's Neme (First, Middle, Last) CHACLES POWELL 4e Facility Neme (If not Institution, give street and number) 821 N EUTAW ST. SUITE 305 5. Social Security Number 243-20-1606 6. Sex 1XM 2 F 78 yrs. 10a. Stele 10b. County MD BALTIMORE 10c. City, Town or Location BALTIMORE 10c. Street and Number 911 ALLENDALE ST. 11. Merital Status 1 Never Merried 2X Merried 3 Wildowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 17. Fether's Neme (First, Middle, Last) UNKNOWN 19e. Informent's Neme/Relationship (Type, Print) GERTRUDE Power Relationship (Specify) 120b. Method of Disposition 1 XBurial 2 Cremetion 3 Remove/from State 4 Donetion Polipsi (Specify) 220b. Place of Disposition 1 XBurial 2 Cremetion 3 Remove/from State 4 Donetion Polipsi (Specify) 23a. Part Enterthe dispasse or complications that caused the ceth. DG not enter the relationship (Specify) 24. Sequentially list conditions, if arty, leading to death but not resulting in the underlying in death) Last 25. Was sees referred to medical coverse (Disposition or subting in death) Last 27. Menner of Death 1 Never of Death 2 Never of Death 2 Nemer of Death 2 Never of Death	1. Decedent's Name (First, Middle, Last) CHAPLUES 46 Facility Name (If not institution), give street and number) 821 N EUTAW ST. SUITE 305 5. Sociel Security Number 243-20-1606 1024 Size 1 No. Sex 2 No.	1. Decedent's Name (First, Middle, Last) CHARLES 46 Facility Nember (Inclinitation), give street and number) 821 N EUTAW ST. SUITE 305 5. Social Security Number 243-20-1606 100 County Number 1	2. Detector Name (First, Model), Last) 2. Detector Ceases (Size and All Number 2. Detector Ceases (Size and	1. Decederate Name (First, Middle, Lace) 2 Desire of Death 2 Desire of Death 2 Desire of Death 2 Desire of Death 3 Desire of Death 4 Death 4 Desire of Death 4 Desire of Death 4 Desire of Death 4 Death 4 Desire of Death 4 Desire of Death 4					



amend item 3	per phys. G786 8/31/00	yf	Certificate o	f Death	Reg.	. No.	0240
	1. Decedent's Name (First, Middle, La	st)			2. Date of Death		3. Time of Death
Physician	Darinka Papich				Avaist	Day 16, 2000	9:40 PM
/Medical Examiner	4a Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Lo	cation of Death	4c. County of Death	
100	St. Elizabeth's	Nursing Home		Baltimore		N/A	
Funeral	5. Social Security Number 6. S		Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Yo	ear) 9. Birth	place (State or Foreign intry)
Director	295-18-8414	80	Yrs.		JAN 11,	1920 Oh	
p .	Usual Residence of Decedent 10a. State 10b. County	10c, Ci	ty, Town or Location				10d. Inside City Limits
f ehow	Monuland Dale		On how and 11 a				1□Yes 2ENo
vith the Menyls to or 28e4 sho be notified at	Maryland Balt Bal	imore	Catonsville	9	10g	. Citizen of What Cou	22
deeth with the Meryland ma 23a or 28a-f show critist be notified an	16 17-1- 1-		2	1228		USA	
020 urs after deeth v at', or itema 23a zam et mitt	16 Wade Avenue	12. Was Decedent Ever in L		of Hispanic Origin? (Spe uban, Mexican, Puerto I	cify Yes or No-	14. Race - Ameri	
5 AM .F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			Hican, etc.)	Black, White,	
5-0020 72 hours after netural, or life	3 Widowed 4 Divorced	If Yes, Give A Year or Dates:	1 ☐ Yes 2 N	lo Specify:		Specify: Whi	te
nd 21215-0 be filed within 72 ho la! hygiene. d other than "neturn went, the fielded	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occ	ne during most of workir	16	b. Kind of Business/Ir	idustry
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60, be asscuted iclan end burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	. 4	uperte	nsion			LOYR
68760, ificate be av a physiclen as the buria	thet initiated events resulting in death) Last	Due to (as a consequence of):	11	1 - 1-	1): 45	70
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cords, P.O. Box 68760, requires that the death certificate be assort the signed by the attending physician and should be detached for use as the bunal-transted by Physician/Medical Examples					1 001 011111		
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Division of Vital Records, or attending Physician: The lew requires the affect of sath. Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed by	Mrs. s.	Deach's			24a. Was an a		Vere autopsy findings
al Record The lew require that has been single 2 should	USTEOP	71 6217			performe	0	vailable prior to completion of cause of death?
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of Vital R. Physicien: The I rel director, page	examiner?	Hospital:	ER/Outpatient 3□ DOA	Other: \		ce 6 Other (Spec	eify)
Physical dispersion of the parties o		28a. Date of Injury (Month, Day Year)			28d. Describe how		
Vision Attending I r death. ector: After by the fune	1 Disjetural 5 Pending investigation			Yes 2 No			
Visa	3 Suicide 6 Could not b	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, street, factory, officially	Ce :	28f. Location (Stree City or Town,	et and Number or Ru Stete)	ral Route Number,
Division (tal or Attending P is after death. el Director: After t led in by the tuner? Certification:		January, die. (open					
Ne Hospital in 24 hours he Funeral pletely filled	29a. Certifier Certifying Ph		owledge, deeth occurred at the ation and/or investigation, in m				
Division To the Hospital or Attent within 24 hours after deal To the Funerel Director: completely filled in by the Medical Certifical		and manner stated.					
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	rucces /	percent !	DE	7/7	1 HO	19UST /	1,2000
4	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	Do:-1	2 actor	UN M	1 71131
	31. Date filed (Month, Day, Year)	22 Pagiatrada Cian	& pilve,	1501516	15/00		21125
State	ALIC 1 0 200	32. Registrar's Sign	4 10- 4	/			



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death August 16,3000 4c. County of Death 6.44am VESTON RAY RAWLS H Under 1 Yeer | H Under 24 Hrs. | 8. Dete of Birth (Month), Days | Hours | Min. | 9/23/1940 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) AA COUNT ARUNDEL HOSPITA 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) 10M 20F Yrs. Norfolk, 224-50-6352 59 Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Anne Arundel Odenton 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 692 Winding Stream Way 21113 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian. Black, Whita, atc. TXXas 2□No 1958-If Yas, Giva Yaar or Datas: 1962 1 Never Merried 2 Merried Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Inspector - Elevators State of Maryland 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Name (First, Middla, Last) Henry Rawls Thelma E. Browney 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Rosemary A. Rawls - wife 692 Winding Stream Way, Odenton, MD 21113 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☐ Burial 2√Cramation 3 ☐ Ramoval from Steta 4 ☐ Donation 5 ☐ Othar (Specify) Dayview Crematory 8/18 Baltimore, MD 21. Signature fun ral Service Licer 22. Nama and Addrass of Facility FINK FUNERAL HOME, PA suggruy lly Gregory 426 Crain Hwy., SW, Glen Burnie, MD 21061 Fink Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, by heart failure. Approximata Intervel Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Preumonia Dua to (or as a consequence of): ienebellar Degenvation Oligogontine Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Diseasa or Injury that initiated evants rasulting in daath) Last Dua to (or es a consequança of): Due to (or es e consequenca of): Part II. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco was contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings svailable prior to complation of cause of death? 24a. Was an eutopsy performad? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. fnjury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No

Examiner The law requires that the death certificate be axed Box 68760. 080 P.O. I Division of Vital Records. Physician: After this or Attending

Health Hem 27

Physician

/Medical

27. Mennar of Death 2 Accidant 3 Suicide 4 Homleida

29a Cartifier

Physician/Medical Examiner by Completed Be edical Certification: To s after death. within 24 hours a To the Funeral C Hospital

Physician

/Medical

Examiner

Director

Funerai

þ

Completed

Funeral

Director

25. Was casa rafarred to medical 1 Yas 2 No

6 Could not be

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, date and place, and dua to the causa(s) end mennar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and menner stated.

28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

29b. Signatura end titla of certifiar MO 29c. Licansa number D50108

29d. Deta signed (Month, Day, Year)

30. Name and addrass of person who completed causa of daath (Item 23e) (Type, Print)

MO Outwood Road Suite 201, blen Burnie MD 2106) Donvino

31. Data filed (Month, Day, Year) AUG 1 8 2000 32. Registrar's Signature

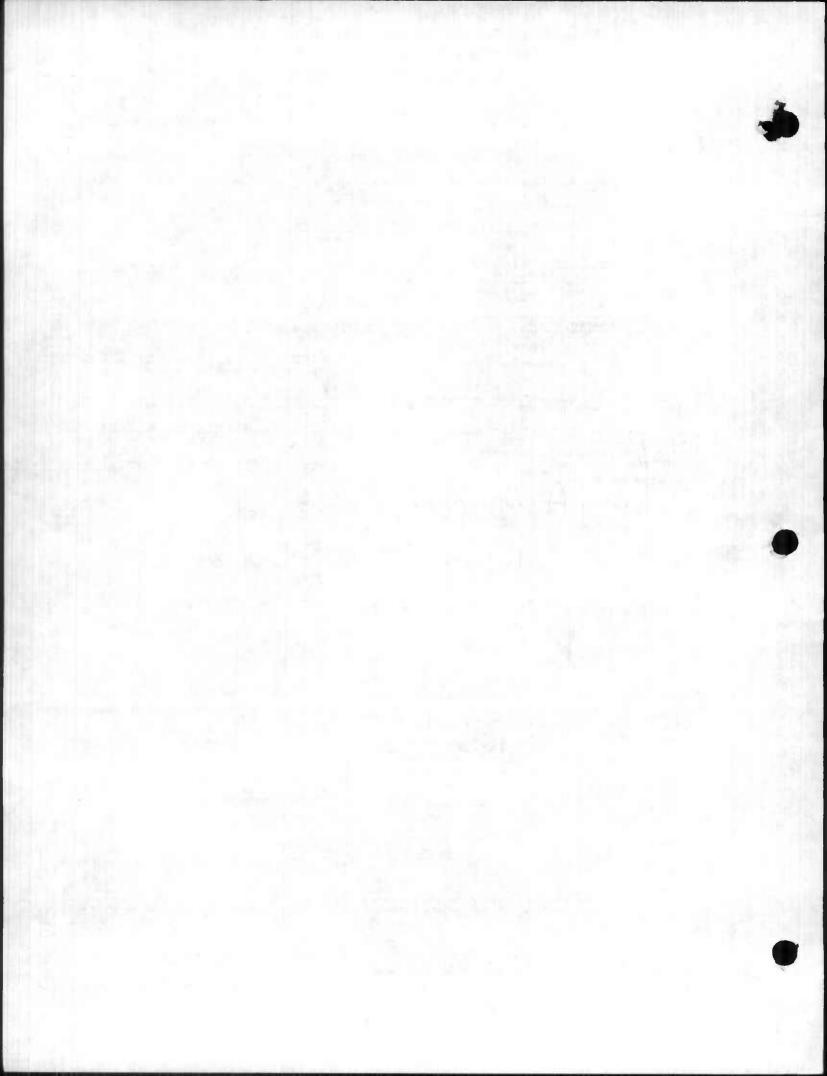
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	Examine	_	4e Facility Name (If not Institution	on, give street	and numb	er)			4b. City, Town, or	Location of Deat	h 4c. County			
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	Funeral Director		5. Sociel Security N 217-40-0 Usual Residence of	0410	6. Sex		Age (In yrs. I	Yrs.	Months Deys						
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	or 28	MD NA Baltimore 10e. Street and Number 10f. Zip Code										10g. Citizen of Whet Country?			
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	s 1 end 2 I Health e tem 27 le other tra				Rando	lph-N	lother	541	O Lynvi	ew Ave,				1215	
Baltimore,	Se of P		20a. Method of Dis		3 Remov	al from Ste	04	ece of Disp emetery, cre	osition (Neme of metory or other ple	ece)	Dete	20c. Location	- City or T	own, Stete	
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Ba	Departme Importan any Injur		21. Signature of Fi	O Oo	Licensee	1/2			2. Name end Addr larch F/						
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F	/Medical		immediate Cause disease or condition	(Final	ľ	not	ristral	-ic	Perta	l Ca	ncor		0 E.V		
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	5 7 8	w	resulting in death)	Last									1		
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on	tending Physeath.	tion	1 Divatural 2 Accident	5 Pend		(Month,	Day Year)	Injury	W	ork?]Yes 2□No	200. 0030100	riow injury occu	1100		
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	he Hoepi in 24 hou he Funer pletely fill	edicai	29a. Certifier (Check only one)		i Examiner: (s of examinat			ime, date and plac opinion, death occ					
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	Registra	ır	A	UG 1 8	2000	15	eneva	B	spar	5					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death EDWIN JOSEPH RENSHAW ,2000 Va 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MERCY MEDICAL CENTER-STELLA MARIS HOSPICE BALTIMORE If Under 24 Hrs. Sex If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours 58 Yrs. 217-38-3827 SEPT. 27,1941 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6506 HOME WATER WAY, SUITE 104 21060 u.s.a. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritat Stetus 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) FRANCIS RENSHAW MILDRED DUDY 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code 21 060 19e. Informent's Name/Relationship (Type, Print) MRS. MARY RENSHAW (WIFE) 6506 HOME WATER WAY, SUITE 104, GLEN BURNIE, MD. 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8/20/2000 1 ☐ Burial 2 Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE, MD. Signature of Funeral S. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., rice Licenser 1 SECOND AVENUE, S.W., GLEN BURNIE, MD.21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Death Poucreotic Corcinomo Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Ves 2 No

Physician /Medical Examiner

physician and s the burial-transit

been signed by should be detac

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death.

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after deatl Director:

To the Hosp within 24 ho To the Fune completely fi

filled in 24 hours a

that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital Attending Physician: Examiner

Physician/Medical

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Completed

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Certification: To

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Director

Nerva 23a or 28e-f show

'natural', or

Hyglene.

h and Mental it

Department of Health ar Important: If Item 27 Is any Injury or other treu

Pages 1 and 2 should be

Baltimore, Maryland 21215-0020

Director

Funeral

Completed

Be

Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical axaminer?

1 ☐ Yes 2 ☐

27. Menner of Death

1 Netural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t.

28a. Dete of Injury (Month, Day Year)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Stother (Specify) HOSPICE 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Investigation

6 Could not be determined

5 Pending

29c. License number

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

29d. Date signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

ercy Medical Ctr 301 #400 Tower Boto MD 21202 St Paul PI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

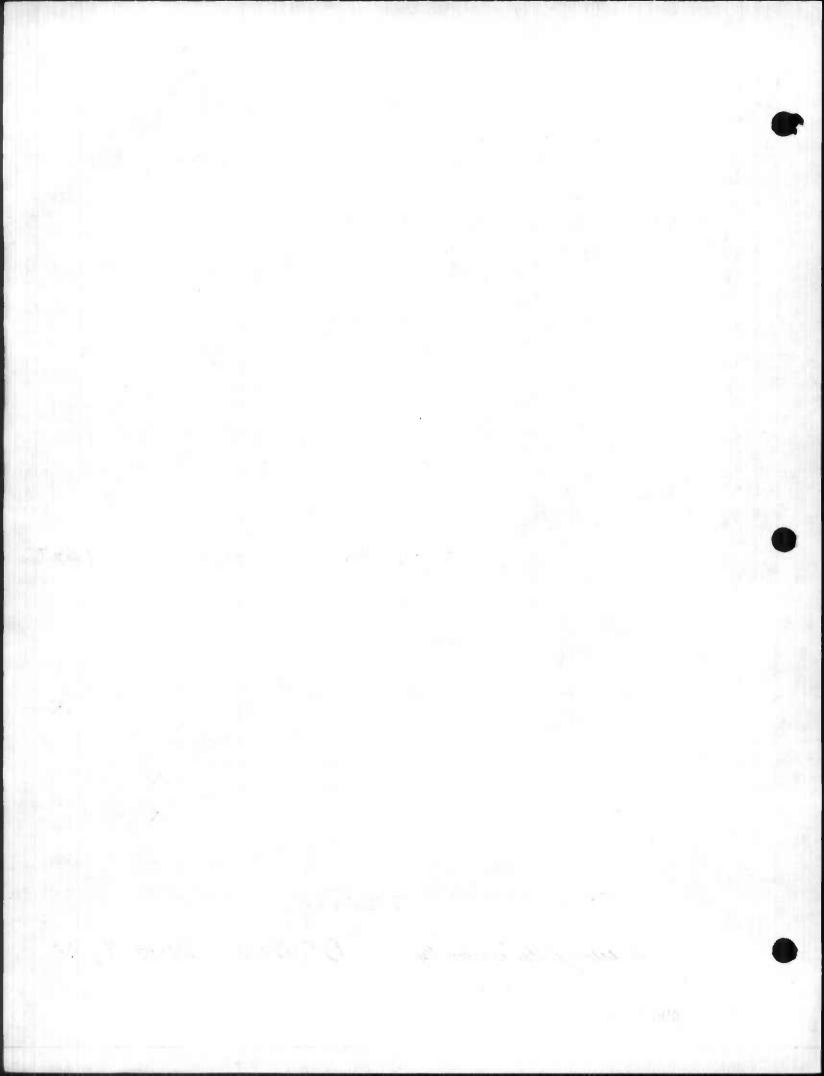
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

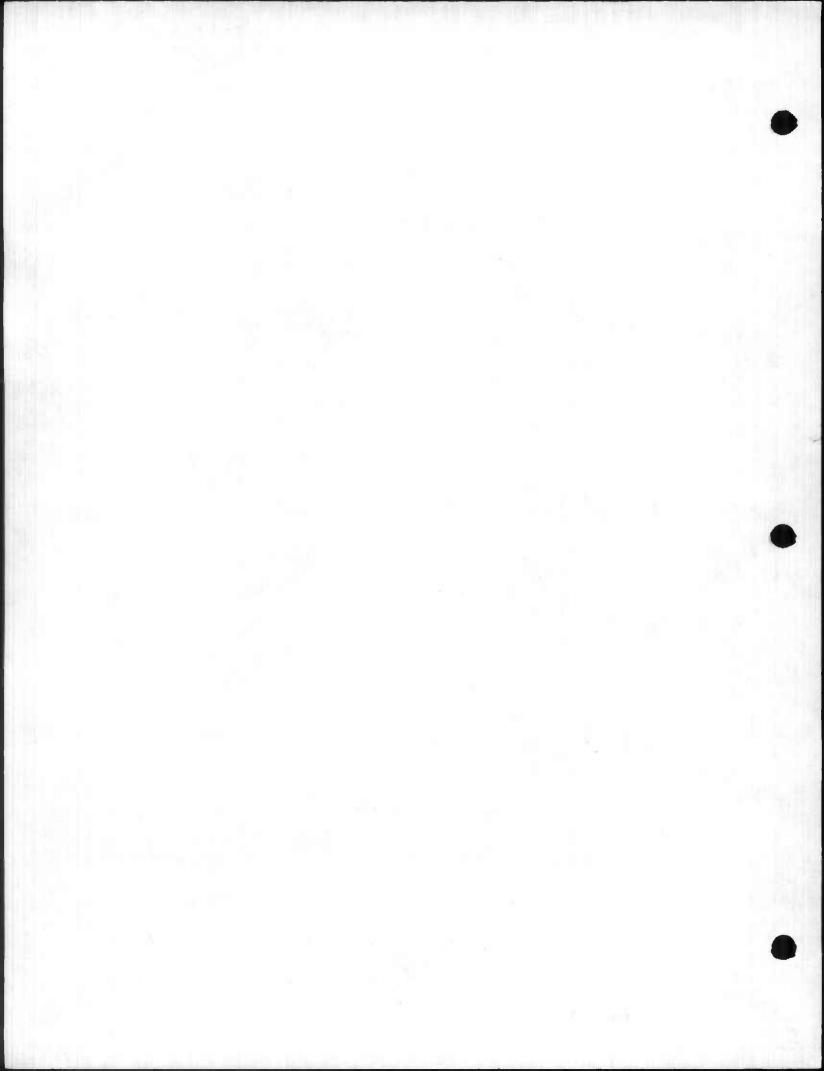
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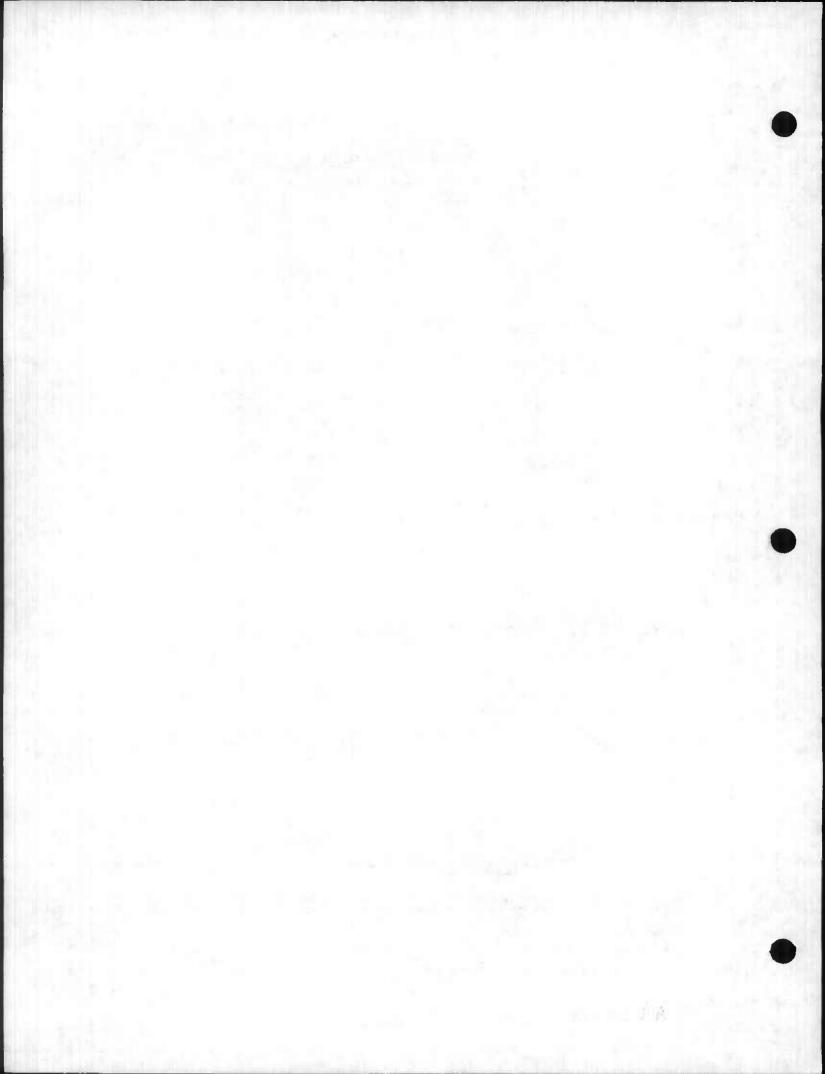


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** EUNICE SCHRAMM ROMING August 16, 2000 3:00 A.M /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 108 Brightwood Club Drive Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) July 5, 1908 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1□ M 25 F Months Days Hours Min. 215-10-6232 92 Yrs. Director Maryland Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Lutherville 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? herns 23s or 108 Brightwood Club Drive 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 'nathural', or altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 8 years the filed within Hygiene. Cher then College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important; if Nem 27 is marked ofth any Injury or other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Schramm Margaret Meehan 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Carl Schramm (nephew) 3112 Gracefield Road Apt. 624 Silver Spring, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8-17-00 Baltimore, Maryland Green Mount Crematory 21. Signeture of Funerel Service Licensee 22, Name and Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. 9200 terrane 6500 York Road 21212 Baltimore, Maryland 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart leiture. List only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Cardiomyopa Examiner Examiner Congestive heart Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): 68760 Atrial tibrillation Physician/Medicai Due to (or as a consequence of) Box Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of degth? 1 Yes 2 No 3 Probably 4 Unknown 2 Chronic obstructive lung disease bengis d be del Records, p 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Be Completed Hypertension 1 ☐ Yes 2 12 No 1 ☐ Yes 2 1 No Division of Vital Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical eleby filled in by the funeral director; 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 27. Menger of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, Ierm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) end manner as stated. 29e. Certifier pletely (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted. within 2
To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18410 30. Name and address of person who completed cause of the eath (Item 23a) (Type, Print) 0 10755 Falls Road Suite 470 Lutherville, MD Laura M. Mumford, M.D. 31. Date liled (Month, Dey, Year) 32. Registrar's Signature State AUG 1 8 2000 Registrar



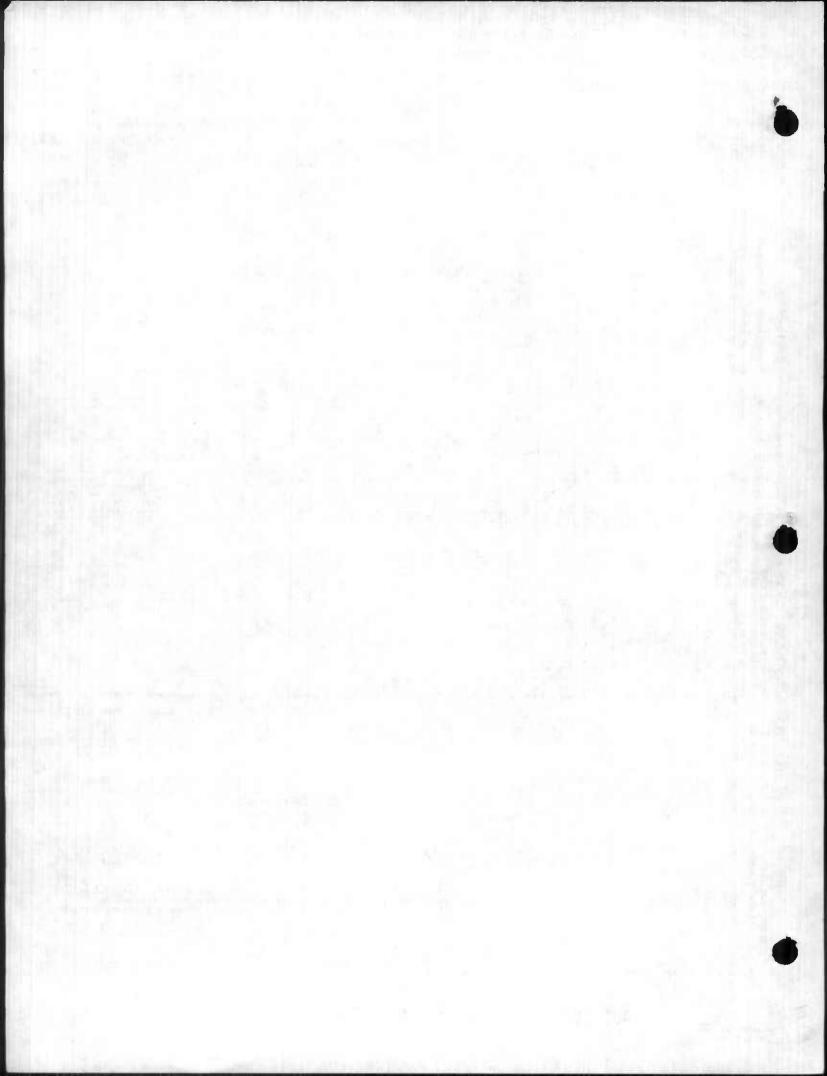
State of Maryland / Department of Health and Mental Hygiene

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	Usuel Residence	of Decedent 10b. County		10c Cit	y, Town or Lo	cetion				1	0d. Inside City Lin	
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Director	10e. Street end			Dette	THIDLE C	10f. Zip Code			10g. Citizen of	What Coun		
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by Funeral	3 ☐ Widowe	erried 2 XMarried	Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates	XNo		If Yes, specify Cub 1 ☐ Yes 2 💢 No		o Rican, etc.)		ck, White, ^{y:} Whit		
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any Injury or other tr	21. Sometime of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc											
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pletely fille edical (29a. Certifier (Check only one)	1X Certifying Ph 2 Medical Exam	ysician: To the besis end menner	of exentine	wledge, deeth tion end/or in	n occurred et the t vestigetion, in my	ime, dete end plece opinion, deeth occu	a, end dua to tha urred et the tima	causa(s) and m data and placa,	annar as s , and due to	tated. the ceuse(s)	
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State of Maryland / Department of Health and Mental Hygiene 00 26252

			1440	Certificate	e of Death		Reg. No.	, ,	20232	
Physician	1. Decedent's Name (First, Middle GEORGE		HAR	DS		2. Date of D Month	eath Day	Year	3. Time of Death	
/Medical Examiner	4e Facility Name (If not institution UNIVERSITS	, give street and number	er)			TIMORE	th 4c. County	of Death	ORE CITY	
Funeral Director	5. Social Security Number 218–14–8024	6. Sex 15 M 2□ F	Age (In yrs. last b	Yrs. If Under Months	1 Yeer If Under 24 H. Days Hours Mi		irth ey, Year) 27, 1923	9. Birthple Count Ga.	ace (Stete or Foreign (ry)	
f show led at	Usual Residence of Decedent 10a. State 10b. County Md. ny	'a	10c. City, Town or Location Baltimore							
Sa or 28s-f s at be notified at Director		1		101. Zip 2	Code 1244	Val.	10g. Citizen of V		ry?	
at, or hams 23 Examiner must by Funeral	3 Widowed 4 Divorced	12. Was Decede Armed Force ed 172 yes 2 [If Yes, Give Year or Date:	s?] No	Blac	14. Reca - American Indian, Black, White, etc. Specify: Black					
ygene. ver then "netur it, the Medical Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12th Grade	's Education t grade completed) College (1-4c	or 5+)	Decedent's Usua (Give kind of woi life, DO NOT us nning Ope	rk done during most of water retired)	vorking	16b. Kind of Bu			
kad other ic event, the	17. Fether's Name (First, Middle, George Richards		11	ming op	18. Mother's N	ie L. Rue	e, Maiden Surnem			
27 is mark r traumat	19a. Informant's Name/Relations Patricia Diggs	nip (Type, Print) daught			(Street end Number or a Road Balt				Code)	
ant: If Ham ary or othe	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)		20b. Place cemet Druic	of Disposition (Nen ery, cremetory or o l Ridge Co	ne of ther pleca) emetery	Aug. 19	20c. Location - Baltimo			
Departi Importa eny Inja ense	21. Signature of Funeral Service	icenses	ls.		d Address of Facility Ni Vynns Falls					
attending physician and increase as the burial-transit clary. Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last		Due to (or as a	a consequence of): TAL a consequence of): consequence of):	HEMAT INFARCT	OMA				
by the etached	Part II. Other significant condition	ns contributing to death	but not rasulting	in the underlying o	ause given in Part I.		tobacco use co		the cause of death?	
s been sign 2 should be pleted by				CERTIFICATION APP	ROVED BY MEDICAL EXAL		s an autopsy formed?	ava	ere autopsy findings allable prior to appletion of cause death?	
certificate has rector, page 2 and Be Comple	25. Was case referred to medical				28. Plece of D	1 Death (Check only	Yes 2 No	10	Yes 2□ No	
ther death. In by the funeral di rtification: To	1 Yes 2 No	ation 7 3	Dey Year) 28b.	Dutpatient 3 DC Time of Injury M Jarm, street, factory	OA Other: 4 Nursing 8c. Injury at Work? 1 Yes 2 No	Home 5 Res 28d. Describe Fall 28f. Location	Sidenca 6 Oth	s fe	ps.	
within 24 hours a To the Funeral D completely filled Medical Ce	29a. Certifier Certifyin (Check only one) 2 Medical	Physician: To the best examiner: On the basis and manner	of examination a	ge, death occurred and/or investigation,	at the time, date and pla in my opinion, death oc	ce, and due to the curred at the time	e cause(s) and ma o, date and place,	anner as strand due to	ated. the cause(s)	
To the comp	29b. Signature and title of certified	flon	JR AN Cart	rical Curp	Ellow // 9	76	29d. Date signe	15/		
6×	30. Name and address of person.	who completed cause of	f death (Item 23a)	(Type, Print) (fimore	e, MD	212	201			
State	31. Date filed (Month, Dey, Year)	2000 32. Regi	strar's Signature	4 1	201					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Yeer SMITH Month **Physician** ILLIAM 06-05 81 AUQ 14 2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Mariner Health Care of Catonsville Baltimore Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) **Funeral** Months Deys 110 M 2□ F Yrs. 83 1 - 24 - 17MD Director 212-12-1058 Usuel Residence of Decedent the Meryland 10a Stete 10c. City, Town or Location 10b. County 10d. Inalde City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Baltimore Director Baltimore 10e, Street end Number 10f. Zip Code 10g, Citizen of What Country? 98 Smithwood Avenue 21228 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?

1 ★ Yes 2 No 1941— Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritai Status Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No Specify: Baltimore, Maryland 21215-0020 Specify: Black Year or Detes: by 3 ☐ Widowed 4 ☐ Divorcad 1952 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry of Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) unknown unknown Chauffeur Transportation traumetic svent. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Pages 1 and 2 should be fill ment of Health and Mentel H ant: If Itam 27 is marked out Be John Henry SMith Lillie Johnson 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mariner Health Care of Catons. 98 Smithwood Avenue, Baltimore, MD 21228 other 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 6 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury or once. 4 Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Feclity . Wade, Director Ronald S State Anatomy Board, 655 W. Baltimore Street Wille Baltimore, MD 21201 23a Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Metastatic /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner 2 Cunom physician end s the buriel-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Box 68760. 8 Physician/Medical Due to (or es e consequenca of): 80 esn signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the cause of death? P.O. entia 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopay findings eveileble prior to completion of cause of deeth? 24a. Wes an eutopay performed? Completed page 2 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 2 No this 28e. Dete of Injury (Month, Dey Year) funeral 28b. Time of 28d. Describe how Injury occurred 27. Menner of Deeth 28c. Injury et Work? Certification: 5 Pending investigation Attending 1 Neturel if or Attending efter death. I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 6 4 Homicide Hospital To the Hospital within 24 hours To the Funeral 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medicai 29e. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year)
Aug 16, 2000 29b. Signature and title of conflier 29c. License number 021649 arkaran 30. Name and aggress of person who completed cause of deeth (Item 23e) (Type, Print) Wilkens Avr. Baltimor MD 21229 SAMBANDAM BASKARAN 3457-

Registrar

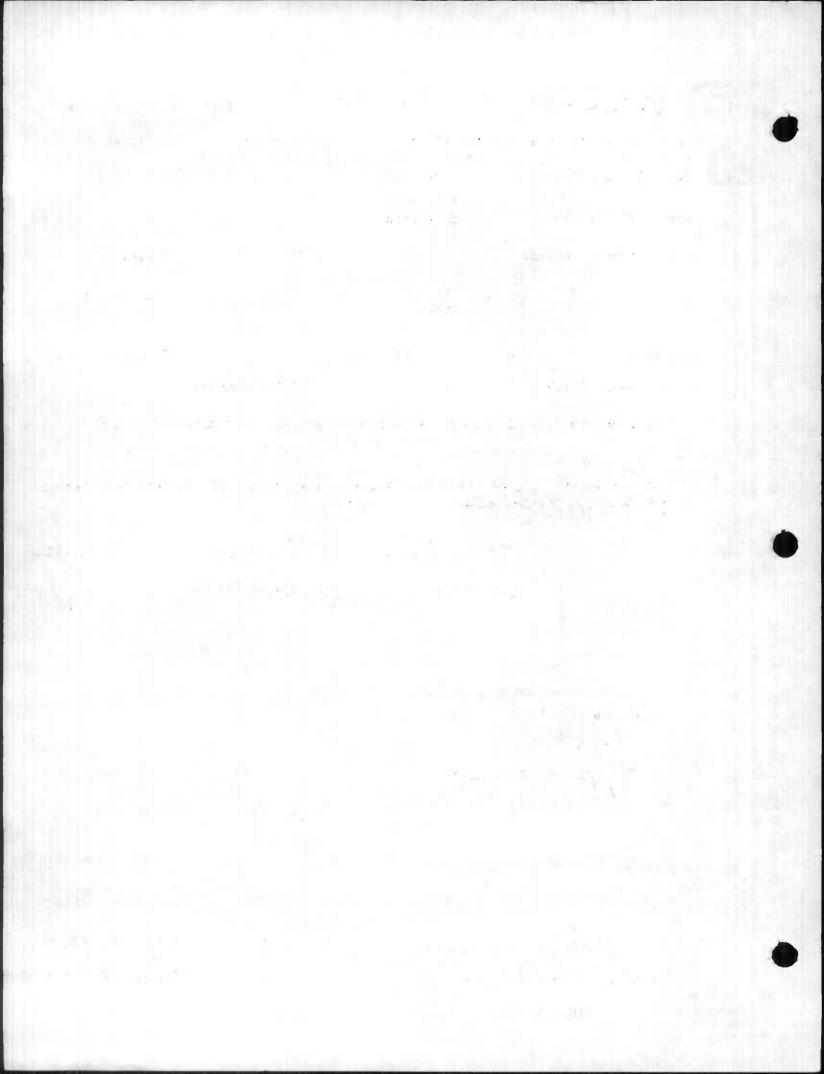
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31. Dete flied (Month, Day, Year)

32. Registrer's Signature

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AUG 1 8 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Day Yaar Month 4, 2000 12:00 PM KURT SUMMERS August 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CASEY HOUSE ROCKVILLE MONTOMGERY 8. Deta of Birth (Month, Day, Year) If Under 1 Year | If Undar 24 Hrs. Birthplaca (State or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 10XM 20 F 66 208-26-3588 April 22, 1934 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Montgomery Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2713 Rambler Place 20783 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Armed Forces. 1 XYas 2 No If Yas, Give 2/53— Year or Datas: 11/56 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 18a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Bustnass/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Sales Newspaper 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) Wilbur Orville Summers Bertha Mae Clinton 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn M. Stroud/daughter 9895 Otis Court, Westminster, CO 80021-5435 20b. Plece of Disposition (Nema of cematary, cremetory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Wade, Director Ronald S. State Anatomy Board, 655 W. Baltimore Street MUDDE Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediata Causa (Finat diseasa or condition resulting in death) leamous Cell Carcinomo of the head treck Dua to (or as a consequence of): Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Completed

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Certification: To

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permit. Page Department of Important: If eny Injury or page.

Physician

/Medical

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Herns ?

Pages 1 and 2 ahould be filed within 72 hours after of nent of Health and Mental Hygiene.
ant: If Hem 27 Ie marked other than "natural", or item ury or other traumatic event, the Heddell Eminal.

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Baltimore, Maryland

68760

Box

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The law

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Affac or Attending Division

after death Director.

24 hours Funeral

Within 2 To the To the

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

24a. Wes an autopsy performed?

2 DA 1 Yes

24b. Ware autopsy findings available prior to completion of cause of death?

26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Mar (Specify) Haspel 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Data of Injury (Month, Day Year) 5 Pending investigation

6 ☐ Could not be

28a. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a, Certifier

3 ☐ Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et tha time, deta and place, end dua to tha causa(s) end manner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signature and titla of certifier

29c. License number 29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) 5 M.O. CASE

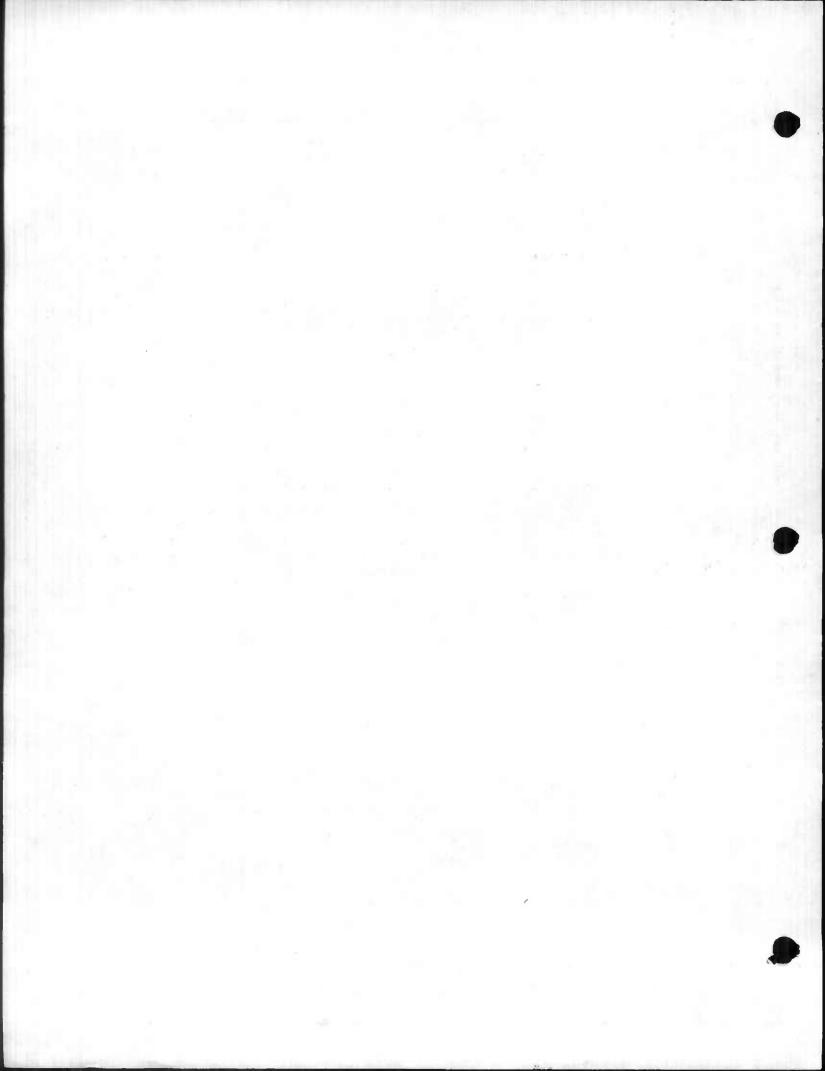
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State

Registrar AUG 1 8 2000

31 Date filed (Month, Day, Year)

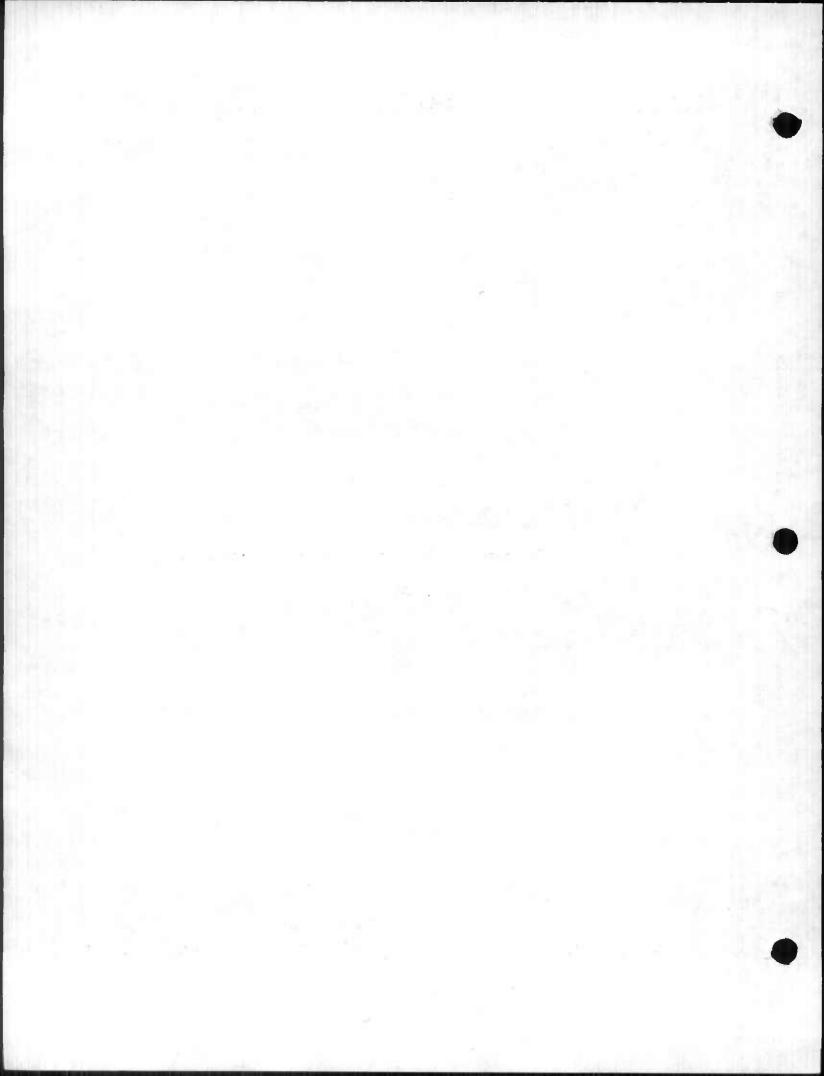
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

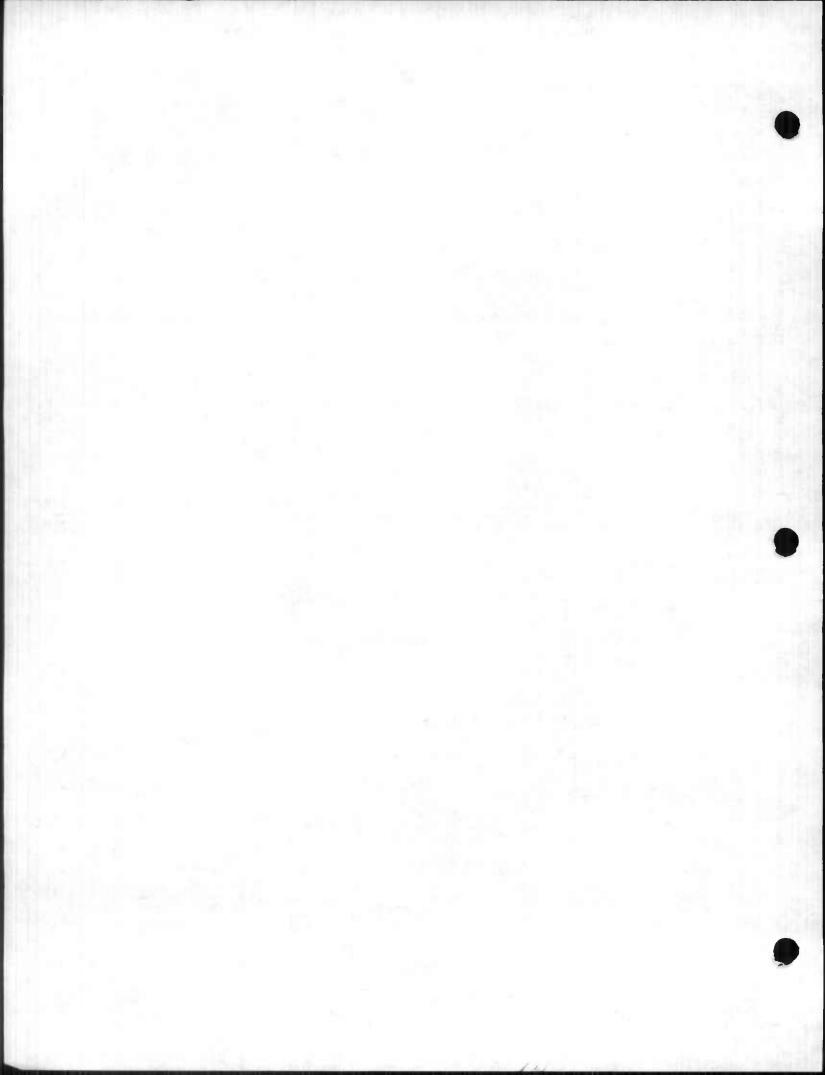
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			Certifica	te of Death		Reg. No.						
Physician	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath	3. Tima of Death					
/Medical	ELIZABETH		HEARILL		18cmin	12 50						
aminer	J.WA, HOSP TAL			DALT	m, or Location of Death		NIA					
neral ector	5. Social Security Number 6. Security Number 1 Security Number 6. Security Number 1	7. Age (In yrs	(S. last birthday) If Under Months Yrs.	or 1 Year If Undar 2 Days Hours	4 Hrs. 8. Date of Bin Min. Month, Da NOV. O	7,1918 S	6. Birthplaca (State or Foreign Country) BOUTH CAROLI N					
	10a. State 10b. County	10c. C	city, Town or Location				10d. Inside City Limits					
Director	MARYLAND A)/A	B	ALTIM	ORE CI	7/	1,K Yas 2□No					
	10a. Street and Number 250 / VIOLET	- AVE APT	-#911 10f. Z	p Code	15	10d. Citizen of Who						
Funeral		12. Was Decedent Evar in Armed Forces?	U,S. 13. Was Dec	edent of Hispanic Origination Cuban, Mexican,	in? (Specify Yes or No		American Indian, Whita, etc.					
by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 25 No If Yes, Give Yaar or Dates:	1□ Yes			Specify:	BLACK					
Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Decedent's Us	ual Occupation	of working	16b. Kind of Bush	ness/Industry					
nple	Elementary/Secondary (0-12)	College (1-4or 5+)		ork done during most use retired)			. 1					
Co	6 HGRADE		SEA	+MSTRE		WYLIEM	ANUFACTURING CO					
Be	17. Fathar's Nama (First, Middla, Last)		. 1		's Name (First, Middle,							
2	DILLY		WILLIAM		RIE		UG BLOOD					
	19a. Informant's Name/Relationship (Ty	1 -	1 45		or Rural Route Number							
	ARTHUR WILLIAMS 20a, Method of Disposition) 2501 VI Place of Disposition (N	OLET AV	E., API, 911	20c. Location - Ci	HORE, MO 2/2/5					
	Burlal 2 Cremation 3 R		cemetery, crematory or	other place)								
	4 □ Donation 5 □ Other (Specify)	u	ESTERN S.	TAR CEMER	5ex8-21-00	CATONS	VILLE, MD.					
8	21. Signature of Funeral Segree Ticense	.)	22. Name 8	and Address of Facility	BROWNJA	, FUNER	VILLE, MD. AL Home					
	Man Hold	rams)	214	ON FUL	TON AVE.	BAITIHO	RE, MD, 21217					
	23a. Part . Enter the disease, or compli shock, or heart failure. List only or	cations that caused the der	ath. Do not enter the mo	da of dying, such as c	ardiac or respiratory a	rrest,	Approximate interval Between					
an cal	Immediata Cause (Final	• 0. 0)	2-20				Onsat and Death					
er	disease or condition resulting in death)	SUPERTOR .	MESENJE AJE	ANTERY	IMAGMBO	818						
9		the second secon	(or as a consequence of):								
Examiner	t t	NECROTIL	BOWEL .									
Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence of	,			1016					
edicai	trial militated events	Due to (or as a consequence of	v								
	resulting in death) Last	500101	tor as a consequence or	,								
N/W												
sician/	Part II. Other eignificant conditions con	tributing to death but not re	sulting in the underlying	cause given in Part I.	23b. Did	tobacco uee contr	ribute to the cause of death?					
Physician					10	Yee 2 No 3	B Probably 4 Unknown					
by P												
Completed by P		F . C . L			24a. Was	an autopsy ermed?	24b. Were autopsy findings available prior to completion of cause of death?					
D T					10	Yes 2 No	1 ☐ Yes 2 ☐ No					
Com							TILITES ZILINO					
o Be	25. Was case referred to medical examiner?	lospital: 🛰		Othor	of Death (Check only							
· -	1 ☐ Yes 2 2 No ☐ 27. Manner of Death	1 Inpatient 2L	☐ ER/Outpatient 3☐ [28b. Time of	- 4L 1401	sing Home 5 Resi	dence 6 LIOther how injury occurred						
Hon	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work?		now injury cocurred						
Cat	2 Accident investigation 3 Sulcide 6 Could not be	20a Diago of Injury At				Street and Number	or Rural Routa Number,					
Certification:	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, street, facto	ry, omice	City or To		or nural nobla Number,					
edicai C	29a. Certifier (Check only one) 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as etated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Medical Cer	29b. Sighatura and title of certifiar	and mainter states.	2	9c. License number		29d. Date signed ((Month, Day, Year)					
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	Mooney Auton	-	11/1	2 (111		40,0031 1	14, LUND,					
7	30. Name and address of person who co						011.0					
	31. Date filed (Marth 1934, Test 201	32. Registrar's Sign	LVEDERE AV	E. DALTII	MORE, HA	KILAND	21215					
State	- AUG 1-8 20	00 32. Hegistrar's Sign	19	book .								



State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificat	e of	Death			Reg. No.	U	26256
	Physician (Medical	Decedent's Name (Find MAX)	irst, Middle, La	st)			SU	GAR			2. Date of De Month AUGUS	Day	Year 1000	3. Time of Deeth 8:30 PM
	/Medical Examiner	4a Facility Name (If not 251	O HAL (mber)	H.			b. City, To		cation of Deatl	4c. County		
	Funeral Director	5. Social Security Numb 112-26-565		Sex I∏M 2□F	7. Age (In yrs	s. last birthday) 83 Yrs.	If Under Months	1 Year Deys	If Under Houra	24 Hrs. Min.	8. Date of Bir (Month, Da MAY 5	y, Year)	Coun	place (State or Foreign of the State or Foreign of the State or Foreign of the State of the Stat
	A show fied at tor	Uaual Residence of Dec 10a. State 10 NY	b. County		10c. C	City, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	an will the Magra 23a or 23a-f sho ust be notified at rai Director	10e. Street and Number 46 CE		ST AVEN	UE		10f. Zip		1516			10g. Citizen of \	What Coun	try?
020	ar, or thems Examiner m by Fune	11. Merital Stetus 1 Never Merried 3 X Widowed 4		12. Was Dec Armed F 1 Yes ft Yes, G Yeer or I	2 No		Was Deced f Yes, spec 1 ☐ Yea	ify Cubi	lispanic Ori an, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	Blac	e - Americ ck, White,	etc.
21215-0020	od within 72 ho ygiene. we than 'naturi it, the Medical.			ide completed)	1-4or 5+)	16a. Deced (Give life. I	tent's Usua kind of wor DO NOT us CARPE	rk done	during mos d)	t of work	ing	16b. Kind of B	WORK	
/land	Mental Hy rikad otha dic event. To Be C	17. Father's Name (Firs JOEL	t, Middle, Last,		D.	SUGAR				or's Name		Maiden Suman		
-	atity and 2 27 is ma er treume	19a. Informant's Name HYMAN SUC		Type, Print) SON			_				a <i>l Route Numb</i> ALTIMOR	er, City or Town, E, MD	Stete, Zip 21209	
imore	nant of He ant: If Nen ury or oth	20a. Method of Disposit 1 Burial 2 Co 4 Donetion 5 C	remation 3 🖁			Placa of Dispo cemetery, crem BETH M	netory or o		ce)	8	Date /16/00	PINELA		own, State IEW YORK
Balti	Departi Departi Importi any inj ang inj	21. Signature of Funera	Il Service Licer	nsee					ss of Facili	SO		SON & B		INC. MD 21208
F	Physician	23a. Part1. Enter the d shock, or heart tai	isease, or comilure. List only	plications that one ceuse on	caused the dec									Approximate Interval Between Onset end Death
	/Medical Examiner	tmmediate Cause (Fina disease or condition resulting in death)		a	Sep:	S/S (or as a consec	quence of):						1	2 day
	n and ial-transit	Sequentially list condition	one	b/		(or as a conseq		de	NEU	mo	NIA			3 months
x 68760,	ing physicia as the bur Medical	Sequentially list condition of any, leading to immediately cause. Enter Underlyin Cause (Disease or injust that initiated events resulting in death) Last	diate g	c		(or as a conseq							1 1 1 1 1 1 1 1	
Box	d by the attendilletached for use	Part II. Other significan	t conditions o	ontributing to d	eath but not re	esulting in the u	nderlying c	ause git	ren in Part I		23b. Dfd	tobacco uss co	ntribute to	the cause of death?
P.0	ned by the detach	MALIG			11/101						10	Yes 2⊠ No	3 Pro	bably 4 Unknown
of Vital Records,	ine law requires that the or late has been signed by the page 2 should be detached Completed by Physic	J									24e. Was	an autopsy ormed?	av co	ere eutopsy tindings ailable prior to impletion of cause death?
al Re											10	21	10	Yes 2□ No
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ion of	Attending Physics of death. Sector: After this of by the funeral direction: To	1 Yes 2 No 27. Manner of Death 1 Naturel 5 2 Accident	☐ Pending	28a. Date (Mor	Inpatient 2[of Injury oth, Dey Year)	28b. Time of trijury		8c. Inju	4 LI N			dence 6 MOth		RESIDENCE
-	7 2 E		Could not b determined	288. Plac	a of Injury - At ling, etc. (Spec	home, farm, str	eet, factory	, offica			28l. Location (City or To		ber or Rure	el Route Number.
:	funer funer fical	29e. Certifier 1 (Check only one)	Certifying Ph Medical Exam	niner: On the b	best of my kr pasis of examination stellar.	nowledge, deeth netion and/or In	occurred vestigetion	et the ti	me, date er pinion, dea	nd plece, ath occur	end due to the red at the time,	ceuse(s) end m date and plece,	anner as s and due to	tated. o the cause(s)
D	within 2 To the comple	29b. Signature and little	of certifier when	Jel	\				se number	39		29d. Date signe	od (Month,	Day, Year)
	Sp	30. Name and address	JAK	bBorit	5,MD	283					B1427	MD 2	120	9
	State Registrar	31. Date filed (Month, b			Registrer's Sign	neture	pho	PER	7					713.00



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND #17 PER F.H. G786 8-18-2000 JAB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SILBERKWEIT Month Year **Physician** MARIA 8:20 Pm AUGUSE 2000 /Medical 4c. County of Death City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Rardallston (4) Baltimore 7. Age (In yrs. last birthday) 96 If Under 1 Year Months Days If Under 24 Hrs. 9. Birthplace (State or Foreign GERMANY 5. Social Security Number **Funeral** Days 1 M XXF Hours Director 577-44-9071 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahon iral, or items 23s or 26s-f show Exemples must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3204 OLD POST DRIVE # 12 21208 U.S.A. death Funeral "natural", or items 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be illed within 72 hours after intent of Health and Mental Hygiene.

The first inside of the than "natural", or its intent of the inten 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: WHITE Š 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-tor 5+) Elementary/Secondary (0-12) DENTIST DENTISTRY Baitimore, Maryland 17. Father's Name (First, Middle, Last) DR. SOLOMON RABINOWITZ 18. Mother's Name (First, Middle, Maiden Sumame) DR. SOLOMON SILBERKWEIT **NECHAMA** (UNKNOWN) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GALA STERN/ DAUGHTER 3605 ANTON FARMS ROAD BALTIMORE, MD.21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages to Department of H Important: If its ARLINGTON—CHIZUK AMUNO 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/14/00 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) CONGREGATION 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21208 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 0 Examiner Physician/Medical Examiner The law requires that the death certificate be asscuted the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) for usa as signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? Certificate has 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? After 5 Pending investigation or Attending 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C The Carthying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

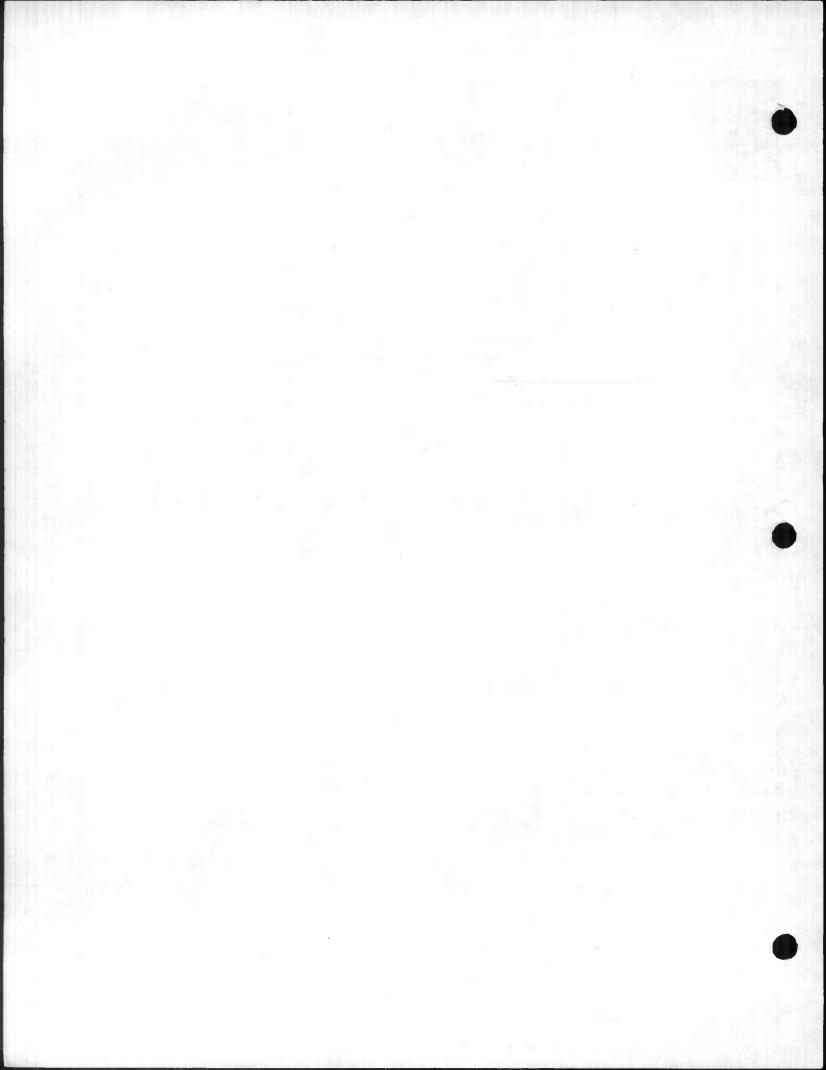
The Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number

Registrar

State

31. Date filed (Mon

32. Registrar's Sign



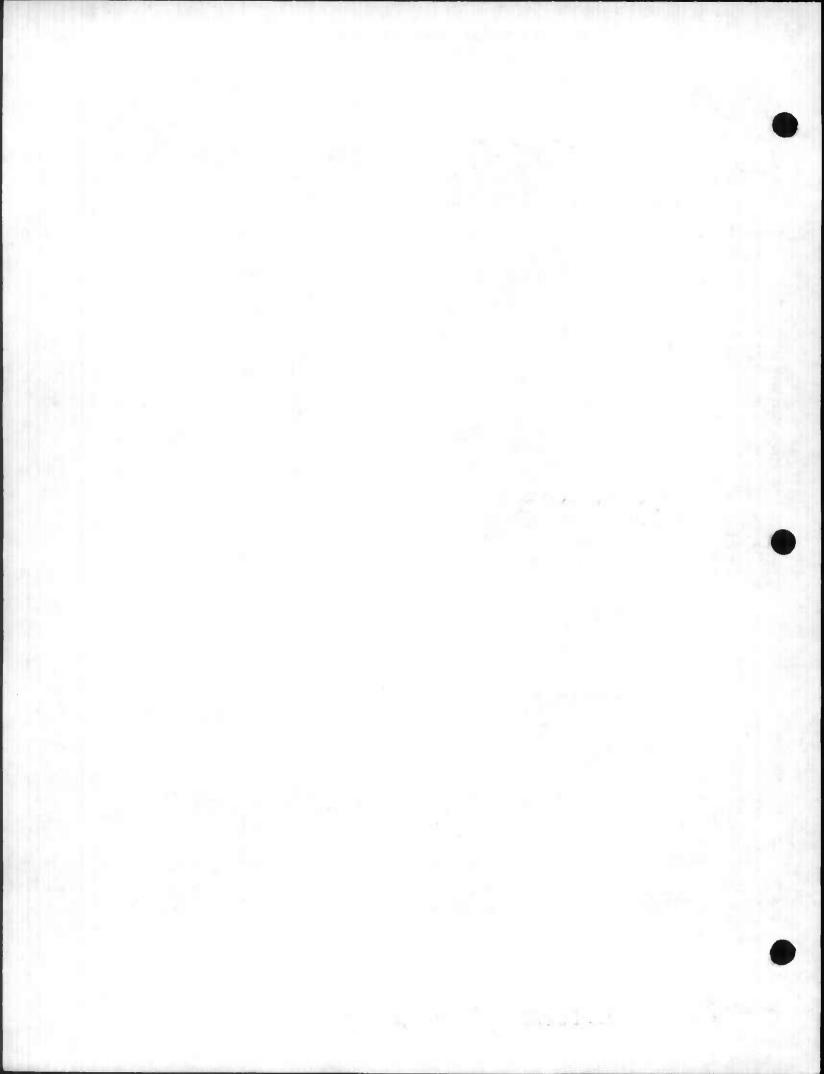
State of Maryland / Department of Health and Mental Hygiene 26258 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** SAWYER ROBERI 9:19 PM UD /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner BALTEMORE BURN MEDICAL CENTER BATVIEW If Under 1 Year | If Under 24 Hrs.

Months | Deys | Hours | Min. 8. Dele of Birth (Month, Dey, Year) NOV. 15,1925 7. Age (In yrs. lest birthdey) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Deys MM 2DF 244-20-1214 74 Yrs. NC Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No Director MARYLAND ANNE ARUNDEL MILLERSVILLE Highens. other than "natural", or items 23s or 28s-1 vent, the Medical Examinar must be notify 10e. Street end Numbar 10f. Zip Code 10g. Citizen of Whet Country? 331 POPLAR ROAD 21108 U.S.A. Funeral Wes Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status filed wilhin 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2X No If Yes, Give altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: WHITE 6 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUILDER CONSTRUCTION 3 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) ey, Maryla Department of health and Nemal introcrant if the matth and Memal any linux or other 27 fair and 27 fair å ROBERT W. SAWYER ALETHIA C. CLIFTON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) MRS. ELLEN UPMAN (DAUGHTER) 1915 LISMORE LANE, BALTIMORE, MD. 21228 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, State 8/21/2000 XX Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK GLEN BURNIE, MD. 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A., 21. Signeture of Funeral Service Expenses 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Perf1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximele interval Between Onset end Deeth **Physician** /Medical fmmediete Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examine The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): attending physician for use as the buna Box 68760, Physician/Medical Due to (or es a consequence of): 60 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given In Pert I. Division of Vital Records, P.O. signed by t 3 Probably 4 Unknown 1□Yee 2□No by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To After this funaral 28e. Dete of Injury (Month, Dey Year) 28b. Time of injury 27. Menner of Deeth 28c. Injury at Work? Certification: or Attending propare 5 Pending Investigation 1 □ Naturel 281. Localian (Street en Number of Aural Route Nymber, City of Town, Stete) 331 POPLAN RP, 11/00 1 Yes 2 No death. 2 Accident 914 Director: / 6 ☐ Could not be 3 Suicide Plede of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Residence MILLERSVILLE filled within 24 hours a To the Funeral C completely filled the Hospital MA edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the lime, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number monthed cause of deeth (Item 23e) (Type, Print) and address of person who co St. #1208 BALTIMORE, NO 2120 115. PHUONG N'GUYETU Evtaw 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State AUG 1 8 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Mary Anne Steinnagel August 16, 2000 8:41 AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 30, 1930 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Months 1 M 2 F Vre Director 216-28-3472 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or itema 23a or 28a-f aho me Medical Examiner must be notified at 1 Yes 2 No Director MD Eldersburg Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5740 Oklahoma Road Funeral 21784 U.S.A. 14. Raca - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 Never Married 2 Merried 1 ☐ Yes 27 No 21215-0020 Specify: White 1 ☐ Yes 2 ☒ No Specify. Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry . Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Regon Life Ins. Company Administrator .. Pages 1 and 2 should be filed v tment of Health end Mental Hygie tant: If Item 27 is marked other t jury or other traumatic avent, to Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Frank Wilson Margaret Lee Carl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Erich Steinnagel (Son) 2061 Conan Doyle Way, Eldersburg, MD 21784 20b. Plece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or 8/19/00 Sykesville, Maryland Lake View Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc BOH. DC 8728 LIberty Road, Randallstown, Maryland 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** · ARTERIOCCLEROTIC CARDIDVASCULAR DISEASE /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the Due to (or as e consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Cunknown Records, by 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: 1 Natural
2 Accident Division or Attending 5 Pending 1 Yes 2 No death. Director: 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

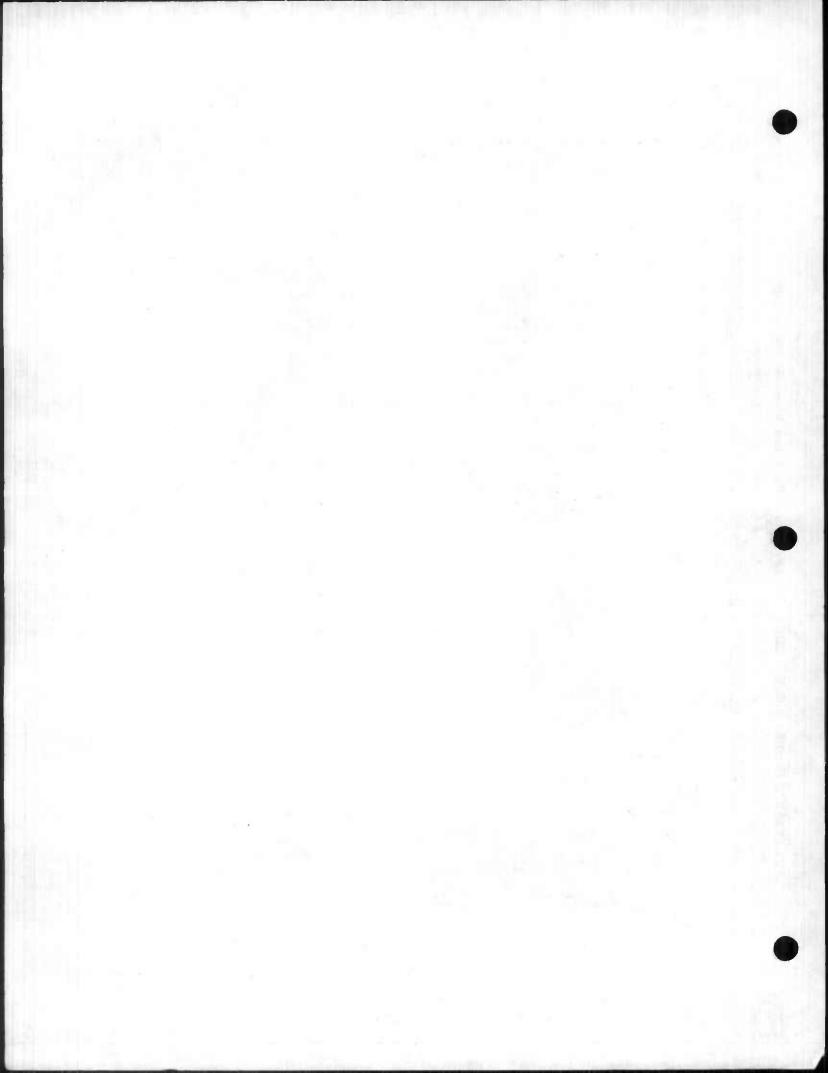
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner steted. 29a. Certifier Sompletely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 024970 AVEVST 16, 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) RANDAZISTOWN, MARYZAND CLISTOMO 5401020 COURT RO FABERIMD 31. Date filed (Month, Day, Year) State AUG 1 8 2000 Registrar

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 00 26260

sician edical			Cer	tificate o	Deam		Reg. No.).	
	1. Decedent's Name (First, Middle, La	st)				2. Date of D			3. Time of Death
edical	Mary	Schwartz				Month	Dey	_	E - 20
	4a Fecility Name (If not institution, give				4h City Town	or Location of Dea		7 2000 County of Deat	5:20 am
miner									
	Sunrise Assisted				Annapo			Anne Ar	undel
	Social Security Number 6. S	ex 7. Age (In yrs. It		If Under 1 Ye Months Der		in. 8. Date of B	irth	9. Birt	hplace (State or Forei
	213-74-4415	94	Yrs.			March	12,19		ania
	Usual Residence of Decedent								
	10a. State 10b. County	10c. City	, Town or Loc	cation					10d. Inside City Limi
ò	MD Anne Ar	rundel Ed	gewate	er					1 ☐ Yes 2 💢 N
Director	10e. Street and Number			10f. Zip Cod			10n Citi	izen of What Co	untov?
	150 -1								, and the second
Funeral	468 Riverview Dr				.037			mania	
1	11, Marital Status	12. Was Decedent Ever in U,S Armed Forces?	S. 13. V	Was Decedent of If Yes, specify C	f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Ame Black, White	
	1 Never Married 2 Married	1 ☐ Yes 2/□(No If Yes, Give		□ Yes ŽŽN					
ı	30XWidowed 4 □ Divorced	Year or Dates:		IL THE ENTE	о зрвину.			Specify:	White
	15. Decedent's Ed		16a. Deced	lent's Usual Oc	upation		16b. Ki	ind of Business/	Industry
Parallel Inco	(Specify only highest gra		(Give I	kind of work do DO NOT use ret	ne during most of ired)	working			
1	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker			Own	n Home	
	None	None	1101110	Indict					
90	17. Father's Name (First, Middle, Last)					Neme (First, Middl	le, Maiden	Sumame)	
0	Nusson Ziets				Chail	ta Cogan			
OC.	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stre	et and Number or	Rural Route Num	ber, City o	or Town, State, I	Zip Code)
	Barbara Seidel	(Daughter)	468 F	Rivervi	w Drive	Edgewat	er.	MD 2103	7
-	20e. Method of Disposition			sition (Name of	W DILVE,	Date	T	ocation - City or	
	1 ☑ Burial 2 ☐ Cremation 3 ☐	00	metery, crem	natory or other p	Nace)	08/19	200. 20	Cation - Only Or	TOWN, State
	4 ☐ Donation 5 ☐ Other (Specify		g Davi	id Mem.	Gardens	2000	Fal:	1s Chur	ch, VA
	21. Signature of Suneral Service Licen	1000 - 11	22.	. Name and Ad	fress of Facility				
	16-11	11.111			_	al Home,			
	· Davier /	was i				nue, Anna		s, MD 2	1401
	23a. Part 1. Enter the disease for companies shock, or heart feiture. List only	plications that caused the death. one cause on each line.	. Do not ente	er the mode of o	lying, such as can	diac or respiratory	errest,		Approximete Intervet Between
								1	Onset and Deeth
	Immediate Cause (Finet	Ono.	man	ia					dance
	disease or condition resulting in death)	a. Pheu. Due to (or	11101	-				ŧ	3
-			as a consequ	uence or):	+ 1	Pailus	00		
Examiner		· conges	DVE		MT	allu	1	1	weeks
ž X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequ	uence of):				1	
<u>"</u>	cause. Enter Underlying								
edicai	that initiated events	Due to (or	as a consequ	uence of):					
	reculting in doubly I get								
	resulting in death) Last								
3	resulting in death) Last	d							
3	resulting in death) Last	d						i	
3	Part II. Other significant conditions of	dontributing to death but not result	lting in the un	nderlying cause	given in Pert I.	23b. Di	d tobacco	use contribute	to the cause of dear
3	Part II. Other significant conditions or				given in Pert I.			-	
3	Part II. Other significant conditions or	dontributing to death but not result			given in Pert I.				
3	Part II. Other significant conditions or				given in Pert I.	1 [Yee 2	No 3□P	robably 4 Unkn
3	Part II. Other significant conditions or				given in Pert I.	1 [Yee 2	psy 24b.	robably 4 Unkn Were autopsy tinding evailable prior to completion of cause
3	Part II. Other significant conditions or				given in Pert I.	1 [Yee 2	psy 24b.	robably 4 - Unknown
3	Part II. Other significant conditions or				given in Pert I.	24a. Wa	Yee 2	No 3□P	robably 4 Unkn Were autopsy finding evailable prior to completion of cause
e Completed by Physician/M	Part II. Other significant conditions of the part is a condition of the par					24a. Wa	Yee 2 as en autoriormed? Yes 2	No 3□P	valeble prior to completion of cause of death?
Be Completed by Physician/M	Part II. Other significant conditions on the part is a condition of the par	ll Carcin	omo	λ	26. Place of	24a. Wa per 1 Check only	Yee 2 us en autoriformed? Yes 2	psy 24b.	were autopsy finding evailable prior to completion of cause of death? 1 Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene 00 26261

					Certi	ificate of	f Death	R	eg. No.	U	2020) [
Physician	_	1. Decedent's Name (First, Middle, La Margaret Rose S				4	N	2. Date of Dea Month Aug.	th	Year	3. Time of (
/Medica Examine		4a Facility Name (II not institution, give Summerville at Weens	e street and number)				4b. City, Town, or L	ocation of Death	4c. County	of Death	7.00	6,107	
Funeral Director		5 Social Security Number 6 9		e (In yrs. last		If Under 1 Yes Months Day	r If Under 24 Hrs.	8. Date of Birth		9. Birtho	place (State or	Forei	
		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loca	ation			10d. tnside City Lim				
Mar al	io	Maryland Carrol	.1	Ma	rriott	tsville					1 🗆 Yes	211	
th with the Marylan 23s or 28s-f show	al Director	10e. Street and Number 7065 Ridge Rd.		Q = I		10f. Zip Code	21104	1	10g. Citizen of What Country?				
urs after dea	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:			as Decedent of Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Blac	e - Americok, White,			
n 72 hours "natural",					6a. Deceder	nt's Usual Occ	upation e during most of work red)	kina	16b. Kind of B	usiness/In-	dustry		
within then.	Completed	Elementary/Secondery (0-12)	College (1-4or 5	i+)		NOT use reti		Homemaker					
THE PART OF	To Be C	17. Father's Name (First, Middle, Last, Edward H. Frailer					18. Mother's Nam	•	Meiden Suman	10)			
ond 2 shoulth and Multh an		19a. Informant's Name/Relationship (Beverly Dannelly				b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip 065 Ridge Rd. Marriottsville, Md. 21104							
nit. Pages 1 al artment of Hea ortant: If Item : Injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Date 19, 2000		tion - City or Town, State tminster, Md.								
Departme Departme Importan any injur		21. Signature of Funeral Service Licer	lost		Eck	chardt	Funeral Chaterstown	napel Rd. Owi	ngs Mil	ls. N	Md. 211	112	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. I						1	Approximate Interval Bety	9	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	1	Onset and D	Jeath								
onded transit	amine	Sequentially tist conditions,	b. AS	C V Due to (or as	s a conseque	ence of):				1	25 yr		
og physician i as the bural	Dey	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. at	Due to (or as	s a conseque	ence of):		a	whent		954	_	
the strands and for use	Physician/A	Part It. Other significant conditions of	dontributing to death be	ut not resultir	ng in the und	derlying cause	given in Part I.	23b. Did to	obacco use co	ntribute t	o the cause o	of dea	
								101	'es 20 No	3 Pro	bably 4 🗆	Unki	
	Completed by			24e. Was a perfor	an autopsy med?	CC	/ere autopsy to valiable prior to empletion of co death?	indin o ause					
ne has	E							1 U Y	es 2 No	11	□Yes 2€	No	
ortifical clor, p		25. Was case referred to medicat					26. Piace of Dea	ith (Check only or					
	0	examiner? 1 Yes 2 No	Hospital:	ent 2 ER	VOutpatient	3 DOA	Other: 4 Nursing H	ome 5 Resid	ence 6,50th	ner (Speci	y assu	it	
or Attending Pri shar death. Director: Attarti I in by the funera	Certification:											7 ber.	
Funer Funer States		29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar	ysician: To the best of niner: On the basis of and manner ste	examination	odge, deeth o	occurred at the estigetion, in my	time, date and place y opinion, deeth occu	, end due to the c rred at the time, c	ause(s) and m dete and place,	anner as s	stated. to the ceuse(s	;)	
828E 4		29b. Signature and title of certifier		29d. Date signe	ed (Month,	, Day, Year)							
5 to 5		1 delinate	TYVZ		2/	7/-	mo						
n		30. Name and address of person who	completed cause of d	leath (Item 23	3a) (Type, P	rint)	D1 1	est m	OFT	110	000	21	
State	e	31. Date filed (Month, Day, Year) AUG 18	32. Registr	pr's Signatur	-88	3 A	KA W	wim	INSTE	1	mr.	2//	

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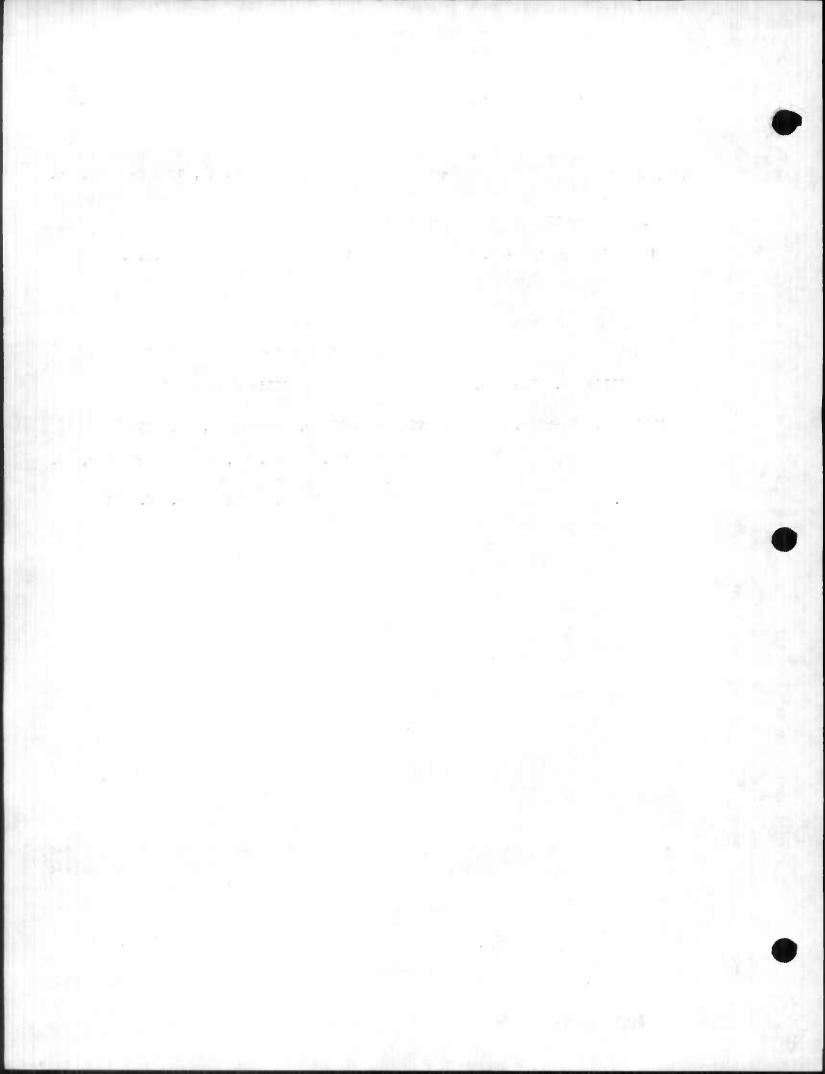
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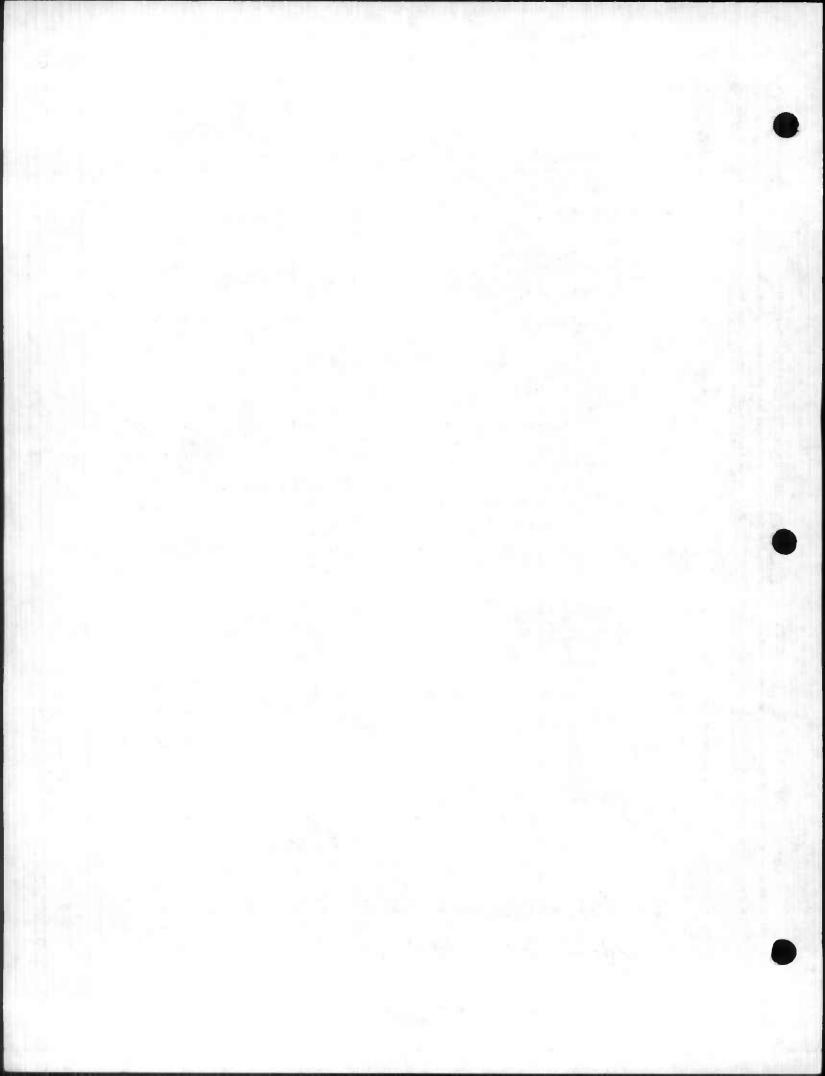
State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	20202				
Physician	Decedent's Name (First, Middle, Last) Jamie Lynn Spealman		2. Date of Death Month Day AUGUST 16 2000	3. Time of Death 0 0353				
/Medical Examiner	4a Facility Name (If not institution, give street and number) MARYLAND SHOCK TRAUMA	4b. City, Town, or BALTIMO	Location of Death 4c. County of Det	ath				
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	. (Month, Dey, Year)	irthplace (State or Foreig Country) Over, Pa.				
ahow id.at	10a. State 10b. County 10c. Cit	y, Town or Location		10d. Inside City Limits				
or 28a-f a	Md. Carroll Ha	mpstead 101. Zip Code	10g. Citizen of What C					
r Itams 23a	11. Marital Status 12. Was Decedent Ever in U Armed Forces? 12. Was Decedent Ever in U Armed Forces? 12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puer	U.S.A. Specify Yes or No- no Rican, etc.) 14. Race - Am Black, Wh Specify: Wh:	ite, etc.				
5	3 Widowed 4 Divorced Year or Dates:							
the m	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Cert. Nursing Assis:						
d out	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Meiden Surneme) ie Jean Spealman					
traumatic	19e. Informent's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or R		Zip Code)				
Important: if item 27 is any injury or other tra	1 ABurial 2 Cremation 3 DRemoval from State	Place of Disposition (Neme of cemetery, cremetory or other place)	mpstead, Md. 2107 Dale 20c. Location · City o . 19, 2000 Manches	or Town, Slate				
any Inju	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Eckhardt Funeral (3296 Charmil Dr.		21102				
the buriel-transit the buriel-transit adjoes Examiner	Due to (or as a consequence of):						
200	Cause (Diseese or Injury that initiated events resulting in death) Last d	or as a consequenca of):						
ed by the attendii detached for use r Physiciary	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part f.	23b. Did tobacco use contribu	te to the cause of deat				
by d		INDEX.	- /	Were autopsy findings available prior to completion of cause				
m De 2			1DQYes 2□No	of death?				
rector. page Co	25. Was case referred to medical	26. Place of De	eath (Check only one)	7				
this certific al director. To Be	examiner? 1 🕅 Yes 2 🗆 No Hospital: 🂢 Inpatient 2 🗆	ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 8 ☐ Other (Sp	pecify)				
	27. Menner of Death 1 Natural 5 Pending (Month, Dey Year)	28b. Time of linjury at Work?	28d. Describe how injury occurred	and the second				
To the Funeral Director: After completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - AI h building, etc. (Specification 2 could not be determined 3 c	G:30 HM 1 □ Yes 2 No nome, farm, street, factory, offica		LOCALION (Street and Number or Rural Route Number City or Town, State) (27, 30, 15, BALSER ROUTE)				
Funerately fills		wledge, deeth occurred at the time, date end plac tion and/or investigation, in my opinion, death occ						
To the Fu	29b. Signature and title of certifier	29c. License number O.C.M.E	29d. Date signed (Mo AUGUST 17	nth, Dey, Year)				
8	30. Name and address of person who completed cause of death (Item JACK MITINS, MID.		, Baltimore, Maryl	and 21201				
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signa	iture A L. A.						



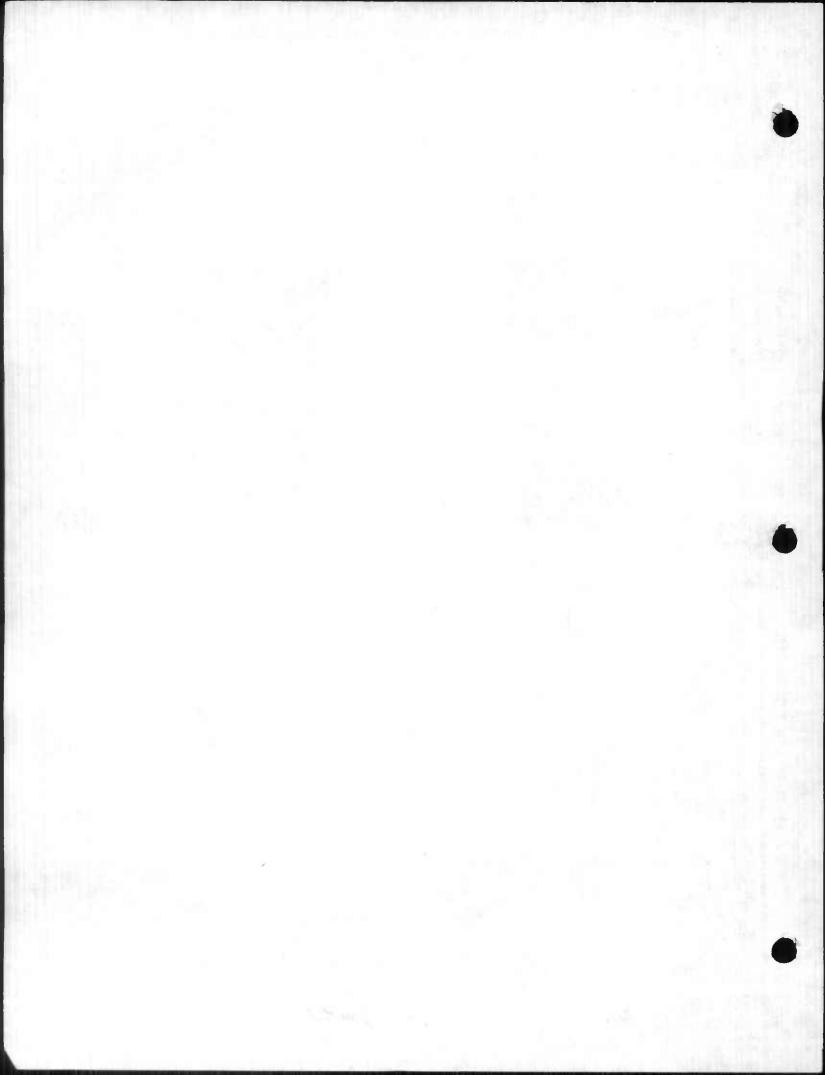
State of Maryland / Department of Health and Mental Hygiene 00 26263

040-05-6746 Usual Residence of Decedent 10e. Stete 10b. County Maryland Baltim 10e. Street and Number 1055 W. Jo 11. Marital Status 1 Never Married 2 Marrie	J. Smyth give street and num Medica 3. Sex 1 M 2 P F	7. Age (In yrs. le 82		If Under	1 Year		DWSC		T 15,	Year 2000 ty of Death Balt i	3. Time of Deat 10:05P			
Facility Neme (If not institution, Saint Joseph 5. Social Security Number 040-05-6746 Usual Residence of Decedent 10b. County Maryland Baltim 10b. Stete 10b. Stete 10b. County Baltim 10c. Street and Number 1055 W. Journal Status 1 Never Married 2 Married	give street and num Medica S. Sex 10 M 20 F	7. Age (In yrs. le 82	ast birthday)		1 Year	T	DWSC	ocation of Deal	th 4c. Coun	ty of Death				
5. Social Security Number 040-05-6746 Usual Residence of Decedent 10e. Stete 10b. County Maryland Baltim 10e. Street and Number 1055 W. Jo 11. Marital Status 1 Never Married 2 Married	3. Sex 1 □ M 2 ☑ F	7. Age (In yrs. la 82	ast birthday)											
10b. County Maryland Baltim 10c. Street and Number 1055 W. Jo 11. Marital Status 1 Never Married 2 Marrie	ore	10c. City			Deys	Hours	Min.	8. Date of Bi (Month, Di 1-21-1	ey, Year)	9. Birthplace (State or Fore Country) Connecticut				
Maryland Baltim 10e. Street and Number 1055 W. Journal Status 1 Never Married 2 Married	ore	10c. City												
1055 W. Jo 11. Marital Status 1 Never Married 2 Marrie			TOWS							10	od. Inside City Lin 1 ☐ Yes 2			
11. Mantal Status 1 Never Married 2 Marrie				10f. Zip	Code				10g. Citizen of	en of What Country?				
1 Never Married 2 Marrie	ppa Road			21	204				U.S.	S. A.				
3€ Widowed 4 Divorced	Armed For	2 No	If	Vas Deced i Yes, spec i □ Yes	ify Cubi	an, Mexice	n, Puerto	ecify Yes or N Rican, etc.)	BI	aca - America eck, White, e ify: Whit	etc.			
15. Decedent's	Education		16a. Deced	lent's Usua	Occup	ation	4 -4		16b. Kind of	Business/Ind	ustry			
(Specify only highest		-4or 5+)	life. E	DO NOT us	k done se retire	<i>auring</i> m <i>os</i> d)	t of work	in <i>g</i>						
12	00.000		Purcha	asing	Age	ent			Westi	nghous	se			
17. Father's Neme (First, Middle, Li	est)					18. Moth	er's Neme	First, Middle	e, Maiden Sume	me)				
Leroy Ernest	Joyce		Ethel Barrett											
19a. Informant's Neme/Relationshi	p (Type, Print)		19b. Mailin	ng Address	(Street	end Numb	er or Run	al Route Numb	per, City or Tow	n, State, Zip	Code)			
Mr. Wilbur C. J	ensen (Att	torney)	22 W	. Pen	nsy:	lvania	a Ave	e., Tow	son, Ma	ryland	1 21204			
1 Buriel 2 Cremation 3 Removal from State cemetery, crematory or other place)														
Dulaney Valley Mem. Gards. 8-21-00 Timonium														
4 Education 3 Education (Episcony)														
Wallace S. Brook, 21 Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204														
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dea														
OCUTE MYOCODIOL INCODETION														
disease or condition														
resulting in death) Due to (or es a consequence of):														
	b									1				
Sequentially list conditions,		Due to (or	as a conseq	uence of):										
cause. Enter Underlying Ceuse (Diseese or injury	c													
resulting in death) Last		Due to (or	as a consequ	uence of):						i				
	d			5 11		- 9								
Pert II. Other aignificant condition	s contributing to de	ath but not resu	lting in the un	nderlying o	euse giv	en in Part	i.	23b. Did	tobacco use c	ontributa to	the cause of de			
SEPSIS								1□	Yaa 2 No	3 Prob	ably 4 Unkr			
TEMENT RE										T 0.45 144-				
RENAL FAILUR	E									ava	re autopsy findin illable prior to noletion of cause			
		7									death?			
								10	Yes 2 No	10	Yes 2000			
25. Was case referred to medicel						26. Place	e of Deat	h (Check only	one)					
1 Yes 2 No	Hospitet:	npatient 2 2	ER/Outpatien	t 3 DC	A Oth	ner: 4 N	ursing Ho	me 5□Res	idence 6 🗆 O	ther (Specify)			
27. Manner of Death	28a. Dete d	of Injury		2	8c. Inju	ry at		28d. Describe	how injury occ	urred				
		n, Day Toar)	injury	М			No							
3 Suicide 6 Could no determin	200. PIECE	of Injury - At horng, etc. (Specify,	me, farm, stre	eet, factory	, office	e. 1				nber or Rura	Route Number,			
(Check only 2 Medical E	caminer: On the ba	isis of examineti	rledge, death on and/or inv	occurred a	at the tid	me, date ar opinion, dec	nd piece, oth occur	and due to the ed et the time	cause(s) and i	menner as st	ated. the cause(s)			
	and menr	ior statect.		200	Licens	se number			29d. Date sion	ned (Month I	Day, Year)			
29b. Signeture end title of cartifier 7. Helon, M.A., D17695 29c. License number D17695 August 15										七 15	2000			
	no completed cause	e of death (Item	23a) (Type I	Print)										
30. Nama and address of person w ABDALLAH J. H					77.1	TILLIE		LICON	MARYL	MAIN .	1 000			
	Leroy Ernest 19a. Informant's Neme/Relationshi Mr. Wilbur C. J 20e. Method of Disposition 1 Ruriel 2 Cremation 3 4 Donetion 5 Other (Spe 21. Signature of Funerel Service Li Wilbur C. J 23a. Part1. Enter the disease, or conditions of the entert failure. List of the entert failure in the disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pert II. Other algnificant conditions SEPSIS RENAL FAILUR 25. Was case referred to medicel examiner? 1 Yes 2 No 27. Manper of Death Neturei 29. Accident 3 Suicide 4 Homicide 29e. Certifier	12 17. Father's Neme (First, Middle, Last) Leroy Ernest Joyce 19a. Informant's Name/Relationship (Type, Print) Mr. Wilbur C. Jensen (Att. 20a. Method of Disposition 1	12 17. Father's Neme (First, Middle, Last) Leroy Ernest Joyce 19a. Informant's Neme/Relationship (Type, Print) Mr. Wilbur C. Jensen (Attorney) 20e. Method of Disposition 1	Purch Purc	Purchasing Pur	Purchasing Agr 12 12 13 14 15 15 15 15 15 15 15	12 12 13 14 15 15 15 15 15 15 15	Purchasing Agent	Purchasing Agent 18. Mother's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Last) 190. Mailing Address (Street and Number or Rural Route Number of Number	Purchasing Agent Purchasing	Purchasing Agent Purchasing			



Dean Topolski

hysician /Medical	Decedent's Neme (First, Middle, L		lbert Top	olski		2. Dete of De Month Augus	t 09 20	Year 000 1	2:25 P.M.
xaminer	4a Facility Nama (If not institution, g		10 Amb	ш.с		or Location of Dear			
	5550 Baltimore 5. Social Security Number 8.		ke Apt. In yrs. last birthdey	**		sville		9. Birthpiace	
neral ector	220-64-3132	10M 20F	36 ^{Yrs.}	Months De	ys Hours M	lrs. 8. Dete of Bi (Month, D Septer	ey, Year) nber 20, 196	Country)	(State or Foreign
	Usual Residence of Decedent								
	10a, Stata 10b. County	1	0c. City, Town or I	ocation					Inside City Limits
Director	MD	Baltimore			Catonsvi	ille			1 ☐ Yas 2 ☐ Nox
	10e. Street and Number			10f. Zip Code		244	10g. Citizen of W		
era!	11 Mt. Green Circ	IE 12. Was Decedent Ev	ar in II S 12	Was Decedent		244	o 14 Bace	U.S	
by Funeral	11. Merital Stetus 1 Nevar Merried 2 Married 3 Widowed 4 Divorged	Armed Forces? 1 Yes 2 No If Yas, Give Yeer or Detes:		If Yes, specify C	of Hispanic Origin? Juben, Maxican, Pu No X <i>Specify:</i>	erto Rican, etc.)	Bleck Specify:	k, White, etc.	
De	15. Decedent's		16a. Dec	edent's Usual Occ	cupation	unding	16b. Kind of Bu	siness/Indust	iry
Completed	(Specify only highest g Elamantary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use ret			В	uilding / 0	Construction
3	unk.				Carpente				
Be	17. Father's Neme (First, Middle, La.				18. Mother's h	Name (First, Middle			
P		bert A. Topolski	1 451 451	40. A.A.	June Hend		od = 1		
	19a. Informent's Neme/Reletionship				eet e <i>nd Number or</i> Green Circle (SIBIU, ZIP CO	U8)
	Mr. Gilbert A. To	polski Fat	20b. Plece of Disp	position (Neme of		Dete	20c. Location -	City or Town,	State
	Buriel 2 Cremation 3			eme <i>tory or other</i> p St. John's C		08/15/200			City, MD
1	4 □ Donation 5 □ Other (Special Lice) 1. Signature of Fundal Section Lice		dress of Fecility	sility					
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-	23e Fert1. Enter the shock, or haert feiluge List on				871 Old Colu dying, such as card			Ap	pproximete erval Between
dical Examiner	Immediate Cause (Final dispesse or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	D	COTIC I ue to (or as a conse	equence of):					
ruysician/medic	that initiated events rasulting in death) Last Part II. Other significant conditions	d	ne to (or es e conse		given In Pert I.	23b. Dic	i tobacco use con	tribute to th	e cause of death?
						10	Yss 2□ No	3 Probab	ly 4 ☐ Unknowr
Completed by							s an autopsy formed?	availa	autopsy findings ble prior to letion of cause oth?
	The second second					1,58	Yes 2□No	1.2(Y	es 2 No
	25. Wes case referred to medical axaminar?					Deeth (Check only	one)		
0	axaminar/ 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient		ent 3LI DOA					Scene
Certification:	27. Mannar of Deeth 1 Neturel 5 Panding 2 Accident investiget 3 Suicide XXCould not	0-9-00		OWN	njuryet Work? 1 □ Yes 2 [X]No	UNK	Home 5 ☐ Residence SQOther (Specify) SC. 28d. Describe how Injury occurred UNKNOWN		
	4 Homicide determine	28a. Place of Injury building, atc. F		NATIO	NAL PIK	Ē ⁰ c₽₽	LTIMORE		
edical	(Check only 2 Medical Expone)	aminer: On the basis of ea and manner stete	ccurred at the time	, date end place,	and dua to the	e cause(s)			
Me	29b. Signatura and titla of certifiar	2	ense number		29d. Date signed	Month, Day	y, Year)		
	Atuals	1 Vla	O.C.M.E.		Augus	st 10,	2000		
	30. Neme and addrass of person wh	o completed cause of dae	th (Ipm 23e) (Type	e, Print)			3		
ate rar	Stephen S, 31. Dete filed (Month, Dey, Year) AUG 182	Radenta 32. Registrar		Penn St	treet, Ba	ltimore,	Maryland	2120	1



State of Maryland / Department of Health and Mental Hygiene

26265 Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** 7 Say 2000 Billy 12:45p.m. Turnage, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner 220 N. Chester St. Baltimore 6. Sex 14 M 2 F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Hours 241-62-5392 Yrs. 60 Director N.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at NA Md. Baltimore Yes 2 No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21231 USA 220 N. Chester St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 t. Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 8th Grade College (1-4or 5+) Maintenance School 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) should be nd Mental is marked Lucy Taylor Turnage 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 st partment of Health and portant: If them 27 is r 220 N. Chester St., Baltimore, Md. 21

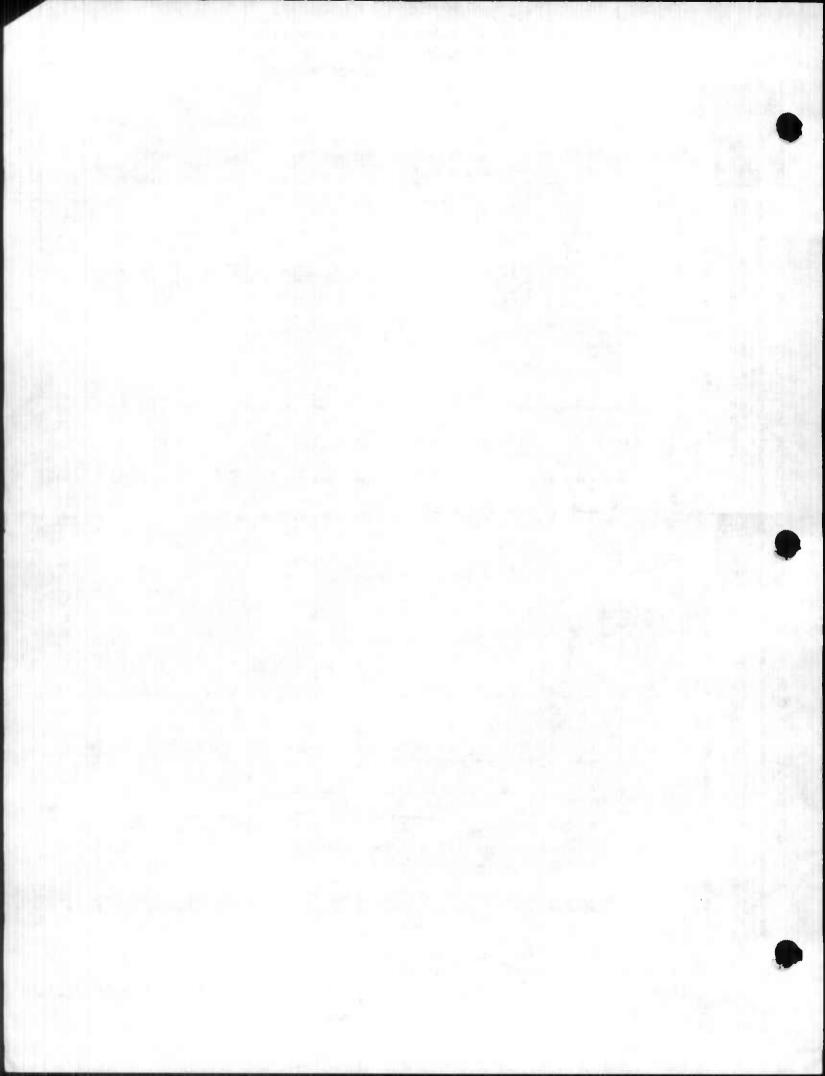
20b. Place of Disposition (Name of cametery, crematory or other place)

20c. Location - City or Town, State Ruby Turnage 21231 Baltimore, 8/21/00 Dundalk, Md. Voshell Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Md. 21202 1101 E. North Ave. la March F.H. East 23a. Pert1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finet netaltic les cares 11 MONTYS diseese or condition resulting in death) Examiner Due to (or es a consequence of Physician/Medical Examine The law requires that the death certificate be executed ed by the attending physician and detached for use as the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed' septal or Attending Physician; The it hours after death, ineral Director; After this certificate ha ly filled in by the funeral director, page 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1@Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier untall Mucan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PULTEI J48VML AVE BALTIMORE Md 21224 4940 TEASTER MICHAEL 31. Dete filed (Month, Day, Year) AUG 1 8 2000 32. Registrar's Signeture

DHMH 16 Rev 6/95

Registrar

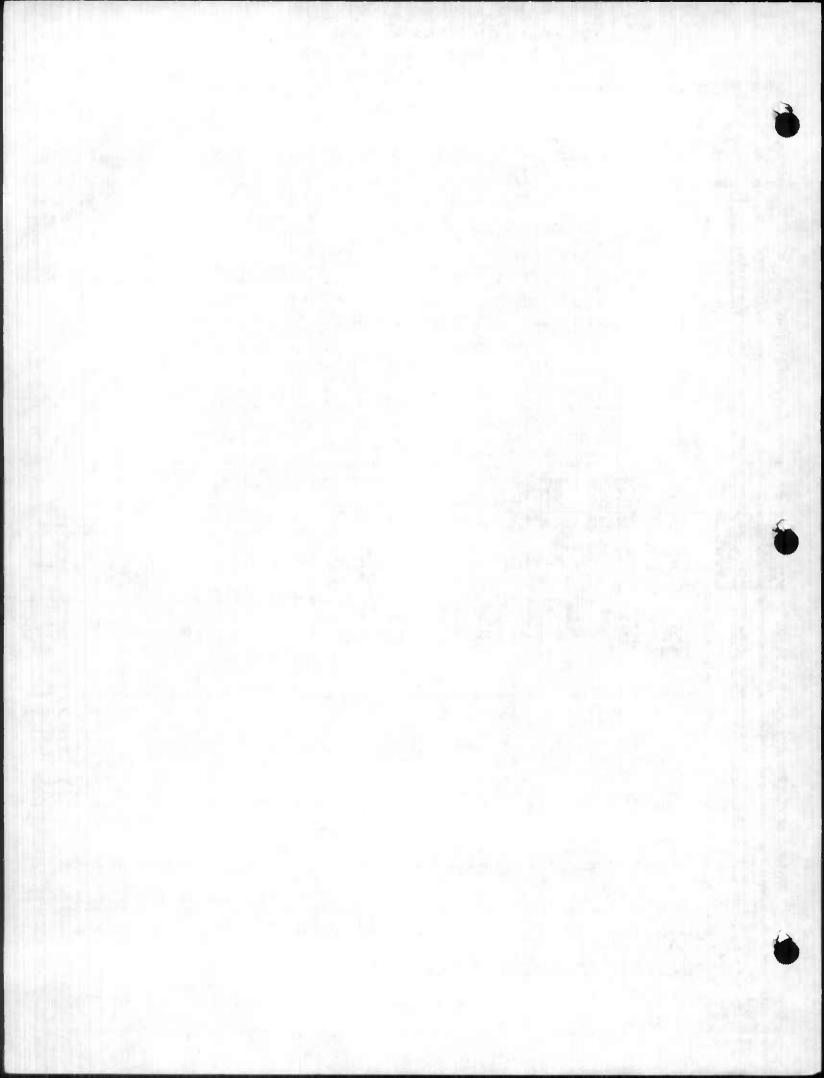


State of Maryland / Department of Health and Mental Hygiene

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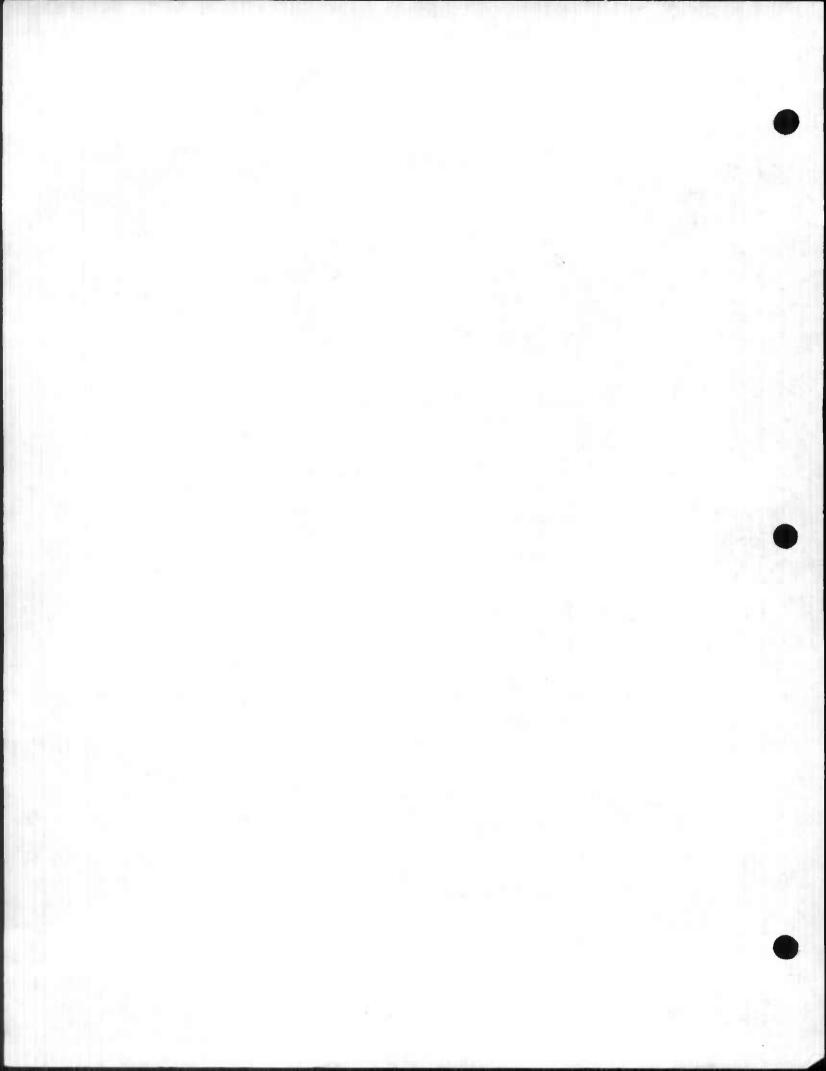
26266

			Certifica	te of Death	F	leg. No.	0 20	200
	1. Decedent's Name (First, Middle, Li	est)			2. Dete of Dee	ith	Year 3. T	ime of Death
Physician	THERESA A	· VON	GLASSNER			16, 200		:10 A.M.
/Medical Examiner	4a Facility Neme (If not institution, gi	ve street end number)	Anna Tes	4b. City, Town, o	r Location of Death	4c. County		
	MANOR CARE RUXT	ON		TOWSON		BA	LTIMORE	
ineral		Sex 7. Age (In yrs.	Month	er 1 Yeer If Under 24 Hi		Year)	9. Birthplace (Stete or Foreign
ector	219-05-1772	1□M 3€F 88	Yrs.		11/7/11		NEW YOR	
	Usual Residence of Decedent 10e. State 10b. County	10c Ci	ty. Town or Location				10d to	side City Limits
5	100. Olato		.,,					Yes 2 No
Director	MD BALTIM	ORE P	ARKVILLE	ip Code		10g. Citizen of V		Δ.
ă		DDTUE						
Fra	2918 KNOLL ACRES	12. Was Decedent Ever in U		21234 edent of Hispanic Origin?	(Specify Ves or No.	USA 14 Bac	e - American Ind	lien
Funeral	11. Marital Status 1 Never Married 2 Merried	Armed Forces?	If Yes, sp	ecify Cuben, Mexican, Pue	erto Rican, etc.)		ck, White, etc.	1011,
by	3 X Widowed 4 Divorced	If Yes, Give Yeer or Detes:	1 ☐ Yes	2 No Specify:		Specify	WHITE	
	15. Decedent's E		16a. Decedent's Us	ual Occupation		16b. Kind of Bu	usiness/Industry	
Completed	(Specify only highest gr	ede completed)	(Give kind of v	vork done during most of w use retired)	rorking			
E	Elementery/Secondery (0-12) 12TH GRADE	College (1-4or 5+)	BOOKKEEPI			RETA	TT	
BeC	17. Fether's Name (First, Middle, Las	1)	DONNEGE		ame (First, Middle,			
To Be C	GABRIEL VALLE			JOHANI	NA GLORIO	SO		
-	19e. Informent's Name/Reletionship	(Type, Print)	19b. Meiling Addre	ss (Street and Number or I			State, Zip Code)
	JACKIE WARD	DAUGHTER	2918 KN	DLL ACRES DR	IVE BALT	IMORE,	MD 212:	34
	20a. Method of Disposition		Place of Disposition (N	eme of	Date	20c. Location -	City or Town, S	tate
	1 Buriel 2 Cremation 3 [4 Donation 5 Other (Speci	_Hemovel from State			3/19/00	DATEMEN	ODE ND	
•	21. Signeture of Puneral Service Lice	/ 110	RKWOOD CEMI 22, Name	end Address of Facility	5/19/00	BALTIM	ORE, MD	
DUC	bolball	150//		OHNSON FUNER	AL HOME,	P.A.		
	23e. Put Enter the disease, or controls, or heart failure. List only	May	8521	OCH RAVEN B	LVD. TOW	SON, MD		oximate
attending physician and I for use as the burial-transit clar/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to to to Due to to	or as a consequence of	winds	is car	1e		
detached for use a					an Did			
ysi	Part II. Other significant conditions	contributing to deeth but not re-	sulting in the underlying	cause given in Part I			3 Probably	
Y						168 2010	3 I Tobably	Pinnoun
D D					24s. Was	an autopsy		topsy findings
Completed by					perfo	med?	available complets of death	ion of cause
me					101	es all'ino	1 ☐ Yes	
Com	25. Was case referred to medical			as moon of the	1/201	Edition Williams	163,168	2019
To Be	examiner?	Hospital: 1 Theoriest 2 C	TERIO description (ACT)	Other	eath (Check only o		de (Spanik)	
	1 Yes 2⊠ No 27. Mapner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe h			
tification	1 Netural 5 Pending 2 Accident investigation		Injury M	Work7 1 Yes 2 No				
Certification:	3 ☐ Suicide 6 ☐ Could not I	28e. Place of Injury - At h	ome, farm, street, facts	ary, office			ber or Rural Rou	te Number.
Ta	4 ☐ Homicide Generalises	building, etc. (Speci	» <u> </u>	-410.10130.	City or Tax	m, State)		
	29s. Certifier 122 Countying P	hyaiclegr To the best of my know	owindge, death occurre	d at the time, date and pla	ce, and due to the	cause(s) and mi	anner as stated.	
edical	(Check only 2 Medical Exa	minery On the basis of examiny and manner stated.	tion and/or investigate	on, in my opinion, death oc	curred at the time,	date and place.	and due to the c	ause(s)
Medical Cert	29b. Signature and title of cartifler	(1/ /2	9c. License number		29d. Date signe	d (Month, Day, 1	rear)
30	D ///	\	// //	1477	26	8-	16-0,)
-1	30. Name and address of person who	completed cause of deal flow	m 288) (Tyon, Print)	TUI	10	0		
	0	7600 OSCER I	Contraction of the later	411 TOWSO	N, MD 21	204		
State	31. Date filed (Month, Day, Year)	32 Bagistfar's Sign	the state of the s	A TONSO	47 CID 23	1604		
State	AUC 1 8 2000	Literal						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Ce	ertificate	e of L	Death		Reg. No	. 0() 2	626	
Ohyalaian	_	ecedent'a Nam	e (First, Middle, La	est)	115					2. Data of Month	Death Da	v Y	ear 3	3. Time of Deat	
Physician /Medical	CT	EVERINO	M. VIANA	4						Aug	15	200	-	2:00 PM	
Examiner	4 1	Facility Name (If not institution, gir	va street end nu	mber)			4	b. City, Town,	or Location of De	ath 4c	. County of	Death		
	45	4 Machia	as Place						Balti	imore			Bal	timore	
uneral	5. S	ocial Security N		Sex	7. Aga (In yrs.	last birthde	/) If Under 1	1 Year Days	If Under 24 Hours	Hrs. 8. Date of (Month,	Birth	9	9. Birthplac	e (Stete or Fore	
rector		32-22-2	2440	X M 2□F	75	Yrs.	Worths	Days	Tiodis	Nov 19			BRAZ		
No H	10a	. State	10b. County		10c. Ci	ity, Town or I	ocation						10d.	Inside City Lim	
must be notified at must be notified at eral Director	MD		Baltim	ore	Bal	timor	е							1 Yas X	
or 28a-f a be notified Directo	10e	. Street and Nu	mber				10f. Zip (Code			10g. Cit	lizen of Wh	at Country	?	
at a	45	4 MACH	IAS PLA	CE			212	220							
here m	11.	Marital Status	4 7 6 3	12. Was Dec	edent Evar in U	J,S. 13	. Was Decede	ent of H	ispanic Origin	? (Specify Yes or ruerto Rican, etc.)	No-		American		
fractine tractine by Fu		1 ☐ Never Marr 3 ☑ Widowed	ied 2 Married 4 Divorced	Armed For 1 Yes If Yes, Given Year or D	No No		1 ☐ Yes 2		Specify:	verto racan, etc.)			White, etc		
ted bet		44	15. Decedent's E	ducetion		16a. Dec	edent's Usual	Occup	ation		16b. Kind of Business/Industry			itry	
4, the Medical Completed	-	(Spec	cify only highast gr	ade completed) College (1	-Aor Sal	(Giv	DO NOT use	e retired	during most of	working					
att E		12	moary (0-12)	Conage (1-401 3+)	Merc	hant h	Mar:	ine		S	eamar	1		
a othe event, Be C		Father's Name	(First, Middle, Last	1)					18. Mother's	Nama (First, Midd	lle, Maider	Sumeme)			
De se o		everino	M. Viana	1					Caroli	ina Unkr	nown				
The Party of the P	198		ame/Relationship	(Type, Print)						or Rural Routa Nur T, Balti				ode)	
m 27 her ty					Onh	1			00021					Ctata	
# 10 00	20a	. Method of Dis 132 Burial 2	position Cremation 3	Removal from	State	cemetery, cr	position (Nemerory or off	her plac		Data		ocation - C		, State	
that the			5 ☐ Other (Speci		ery	08/18/200	Bal	timor	e MD						
to di di	21.	Signature of Fu	ineral Service Lice	nsee	ss of Facility	ome, P.A.									
E 5 8		1 (4		Kare	10411					Baltimore,	MD 21	222			
	23	a. Part1. Enter t	he disaase, or con	nelications that o	eused the dea	th. Do not e	nter the mode	of dyin	g, such as cer	rdiac or respirator	arrest,		A	pproximate	
sician		Shock, or nea	int failure. List only	one cause on e	acri ime.								0	pproximate tervat Between nsat and Death	
edical	Imr	nediate Cause	(Final	1	0.0	(1.		551 05	2.1	0.00		15.00	
niner	Immediate Cause (Final disease or condition resulting in death) Arterios (levotic Candiouascular) isease /												yeu		
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physician and its the burial-transit edical Examir	ras	ulting in death)	Last		Due to (or as a cons	equence of):						\$		
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signed by the attending d be detached for use a d by Physician/M															
bed bed	Pari	It. Other signif	licant conditions	contributing to de	eath but not re-	sulting in the	underlying ca	use giv	en in Part I.	23b. D	id tobacco	use conti	ribute to th	ne cause of dea	
P etac		Maln	utrit	100						1	☐ Yea :	2□ No :	3 Probal	bly 4 Unkr	
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rector, pag		Was case refer	red to medical					-	26 Place of	Death (Check on	(v one)	7.			
director, page		examiner?		Hospitat:	Inpatient 2	TER/Outpati	ant 3[] DO	Oth	er:	L/		6 Other	(Specify)		
		Manner of Deat				28b. Time		Bc. Injur Wor	4 □ Nursi y at	28d. Descri					
Director: After I in by the funer ertification		1 Naturat	5 Pending invastigation		of fnjury th, Dey Year)	Injury			k? Yas 2 ☐ No						
In by the funeral in Certification:		2 Accident 3 Suicida	6 ☐ Could not b	De Diese	of lainer as h	nome ferm					n (Street a	nd Numba	r or Rural B	Route Number,	
in the		4 Homicide	determined	4 259. PIRCE	of Injury - At h	ify)	niet, lactory,	, onice		City or	Town, Stat	(e)	. V. HUIOI F		
ů ů															
pietaly ti edical	291	Check only		miner: On the b	asis of examin					otace, and due to to occurred at the time					
										001 0		(14 D	Vess		
100 N	296. Signature and title of certifier 29c. License number							e number			ate signed				
/	/	P min	PATELLI MU	Dep	uti) 9	5667	7	Auc	ust	17. 2	2000	
7 6	30.	Name and addr	ess of person who	-	e of death (Ite	m 23a) (Typ	e, Print)	, ,	4						
T.	P	WiliP N	1:1:10/2	MY SL	ockT		- 7	5	Gron	ne ST. T:	39/1/11	more	Md	2120	
Ctata	31.	Date filed (Mon	th, Dey, Year)	32 F	legistrar's Sign		,		-	. ~ 0 (1	., , , .		1		
State		AUG 1 8	2000	Bener	× 3	1	marko								
Registrar															



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2 6 2 6 8 State of Maryland / Department of Health and Mental Hygiene ${\sf U}$ ${\sf U}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Warren Alexander Whealton, Jr. August 16, 2000 10:00 a.m. 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street and number) 4c. County of Death 514 Cranford Road Essex Baltimore 8. Dete of Birth (Month, Dey. July 5, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthdey) Months Deys Hours 217-24-5793 XXM 2 F 73 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 20No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 Cranford Road 21221 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bieck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2K) Merried 1 ☐ Yes 2 ☑ No Specify. Specify: White Korean 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Lithographer Printing 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Warren Alexander Whealton, Sr. Mildred Hodges 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Marie Joan Whealton (wife) 514 Cranford Road, Baltimore, Maryland 21221 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burlel 2 □ Cremetion 3 □ Removel from State MeadowRidge Mem. Park 8/19/2000 Baltimore, Maryland 4 Donetion 5 Other (Specify) 22. Name end Address of Facility 21. Signeture of Funeral Service Licenses Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a Part: Effective disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Finel ostatic disease or condition resulting in deeth) Due to (or es a consequence of): Due to (or es a consequence of):

Physician /Medical **Examiner**

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The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vitai Records,

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Towns To the

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Physician

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10a. State

Director

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Department of Health Important: If Item 27

Pages 1 and 2 should be

Maryland 21215-0020

Saltimore,

the Medical Exertiner must be notifi

Physician/Medical Examiner Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

Due to (or es a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

semo

23b. Did tobacco use contribute to the cause of death? 15 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Wes case reterred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

27. Menner of Death 1 Neturel 2 Accident

3 ☐ Suicide

4 Homlcide

5 Pending investigation 6 Could not be determined 28a. Dete of tnjury (Month, Dey Yeer) 28b. Time of Injury 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how Injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and pleca, and due to the ceuse(s) and menner steted.

29b. Signature and little of certifier 0 aun

29c. License number MD

29d, Date signed (Month, Dav. Year) ,17,2000

30. Neme and address of person who completed cause of deeth (Item-23a) (Type, Print)

6830, sule SLUASALUAM 31. Dete filed (Month, Dey, Year)

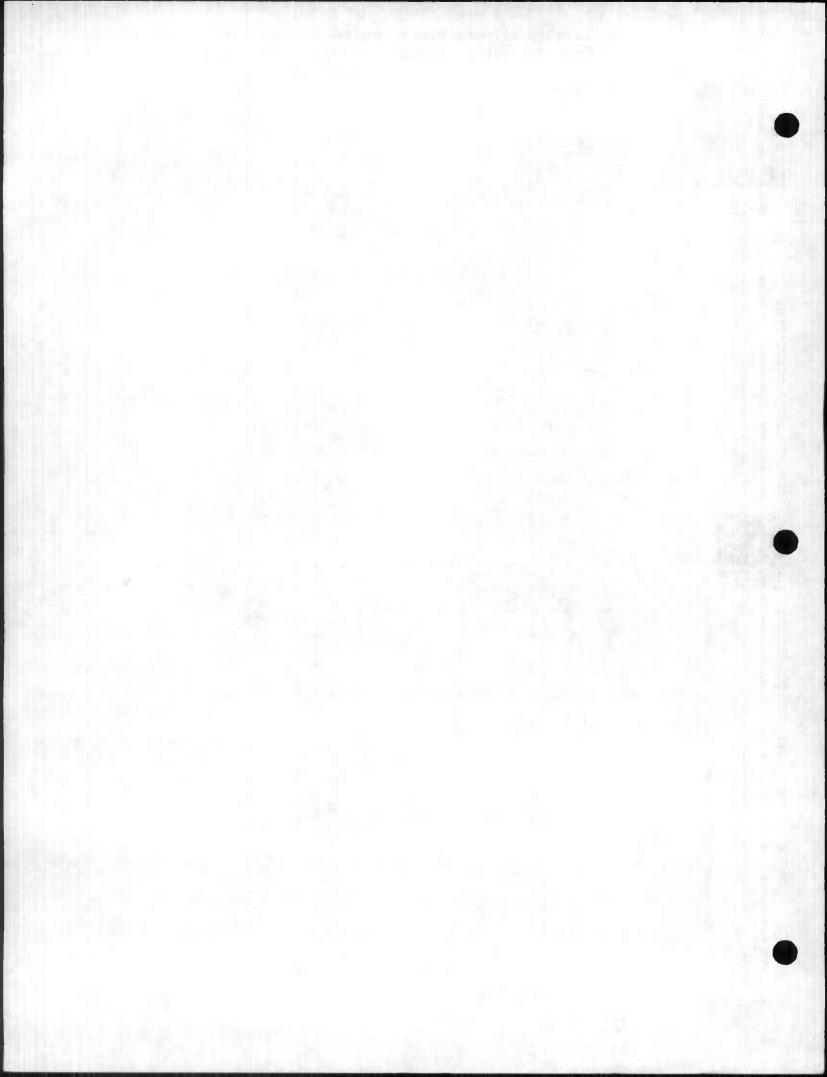
32. Registrer's Signeture

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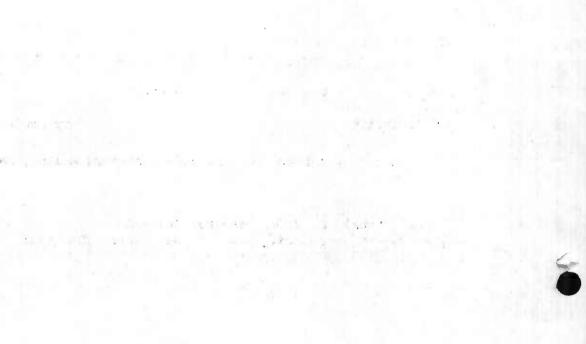
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State of Maryland / Department of Health and Mental Hygiene 00 26269

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Physicia	_	PAUL W. WATKI	NS									AUGUS		ay 200		4	:08 PM	
' /Medio		4a Facility Name (If not institution	_	re street and nur	mber)					4b. City, Tov	vn, or Lo	ocation of Deat		c. County				
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E		5. Social Security Number				In yrs. last bii	thday)	If Under	1 Yeer			8. Dete of Bir (Month, De	th		-	piaca (S	tate or Foreign	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 08 **Physician** 3:40 A.M enora arner 62000 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenwald Nursing Home Towson Baltimore 5. Social Security Number If Under 1 Yeer If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Deys Hours Months Yrs. 219-28-6984 91 Director July 16, 1909 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ns 23a or 28a-f show 1 ☐ Yes 2 No Directo MD Baltimore Timonium 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Chantry Road Funeral 21093 USA Neme 2 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Year or Dates: 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. filed within 72 hours efter 1 ☐ Never Merried 2 ☐ Merried 21215-0020 ò 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced "netural". 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) . Peges 1 and 2 should be fit ment of Health and Mental Hant: If them 27 is marked oth lury or other traumatic aven Edward Richmond Holden Lillian Blanche Ports 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mildred Wannen/Sister 216 Chantry Road Timonium, mD 21093 20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date Aug. 18, Department important: If any injury or Loudon Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Survivo Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael Flagle J. 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finat disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 physician Physician/Medical the 080 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 20 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed certificate 1 ☐ Yes 2 ☐ No Attending Physician: funeral director. 25. Was case refarred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 25 No Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Dec 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 (ANatural 2 Accident 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 □ Yes 2 □ No the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29s, Certifier Medical onw)

State Registrar

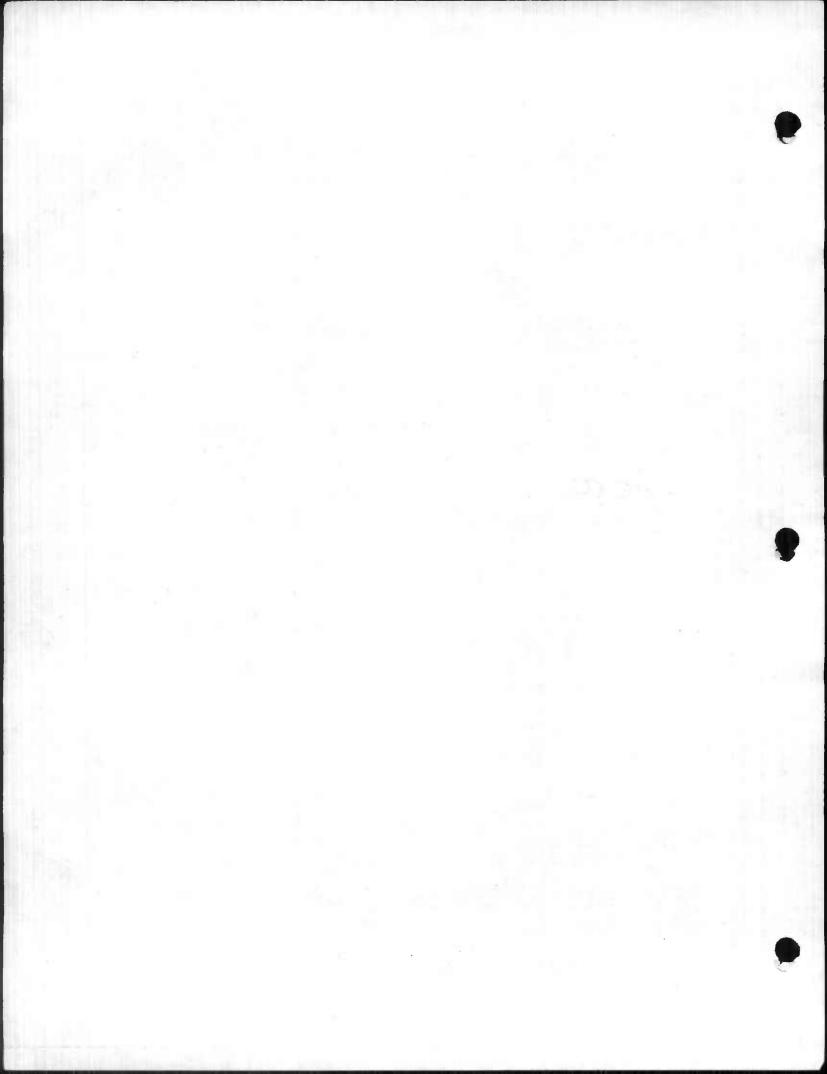
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se of death (Item 23a) (Type, Print)

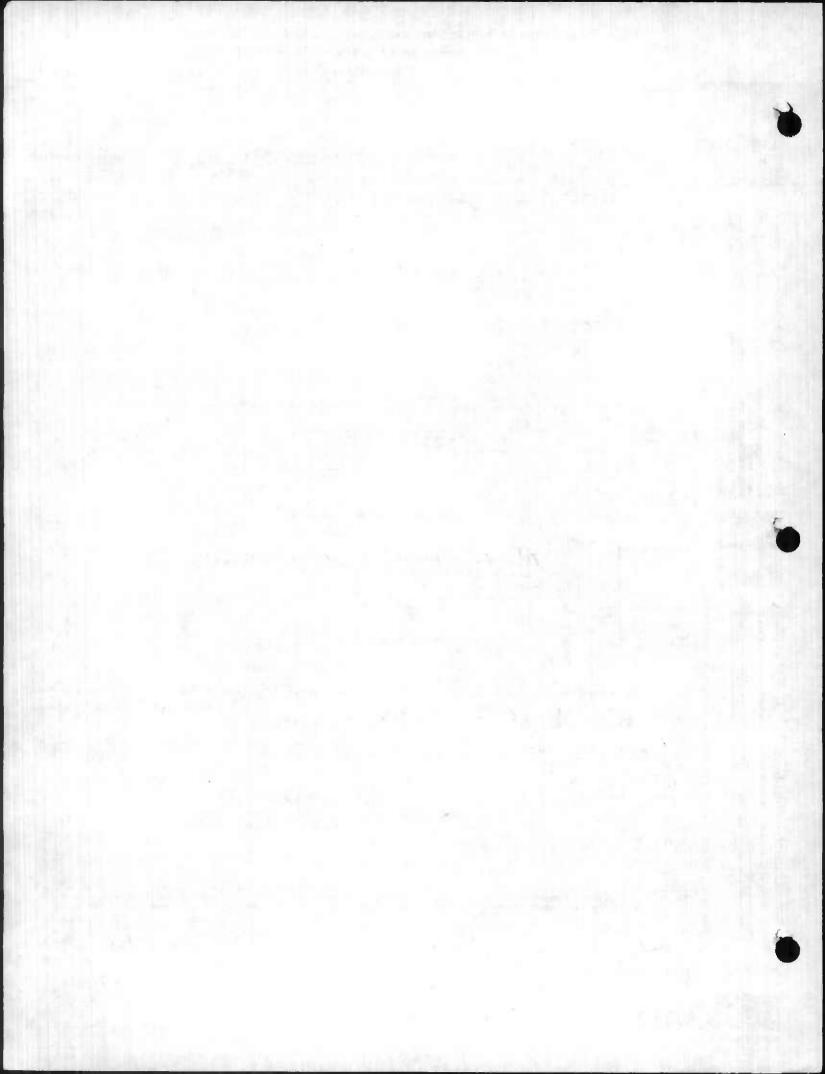
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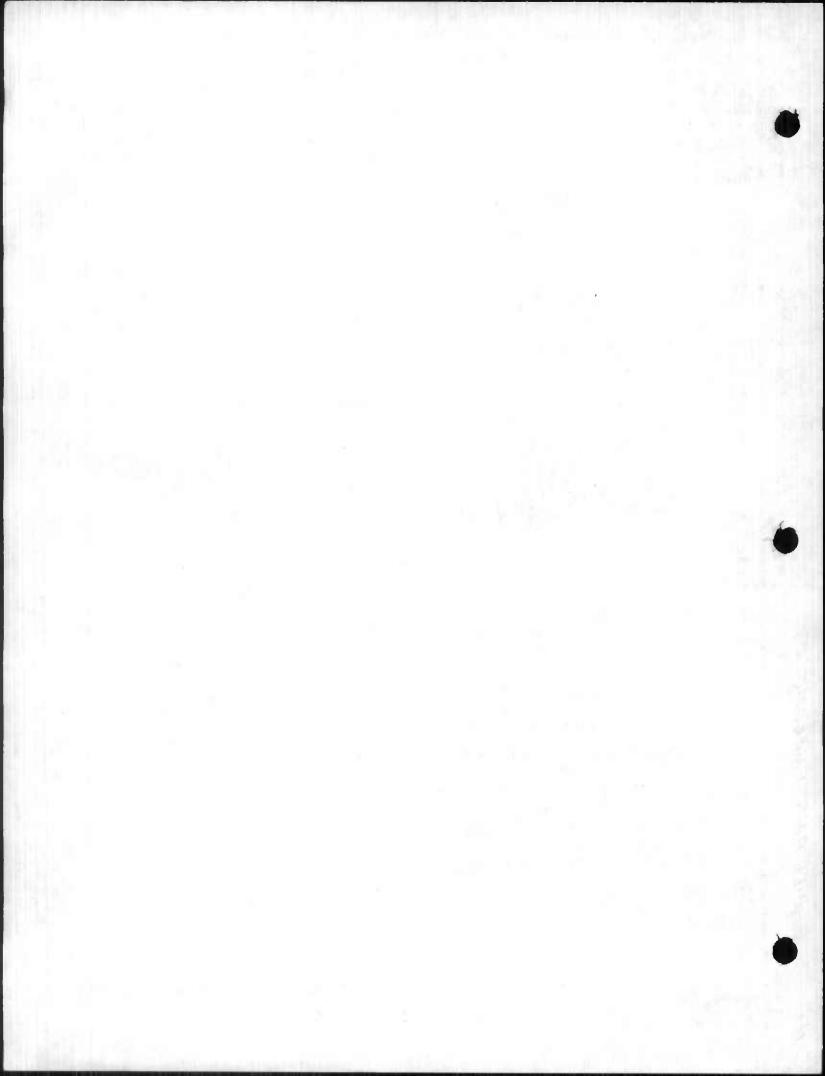
State of Maryland / Department of Health and Mental Hygiene

				Cert	ificate of	Death		Reg. No.	0 20211
A pt	Physiciar /Medica	Decedent's Neme (First, Middle, Last) HELEN E. WILLIAMS					2. Date of De Month AUG	. P\$ 20	3. Time of Deeth 17:05 PM
	Examine	4a Facility Neme (# not institution, give street GOOD SAMARITAN HOSP]	TAL - ER			4b. City, Town, or Baltimor	e City	Balti	more City
L	Funeral Director	5. Sociel Security Number 6. Sex 1 M M Usuel Residence of Decedent	7. Age (fn yrs. les	Yrs.	If Under 1 Year Months Days		8. Dete of Bi (Month, D	17,1919	9. Birthplace (State or Foreign Country) Maryland
	or 28a-f show be notified at	10a. Stele 10b. County Maryland Baltimore C		Town or Local	imore C	ity			10d. Inside City Limits XXYes 2 □ No
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imore,	Pages 1 a nent of Hear ary or othe	20a Method of Disposition AM Burial 2 Cremetion 3 Remon	rel from Stete Gar	nca of Disposi metery, crema DENS 0	tion (Name of trony or other plants Faith	cem. 8-	18-00	20c. Location - Baltimo	City or Town, State re, Md.
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	20	30. Nema and address of person who comple 8 5 5 PA (A DE) 31. Dete filed (Modifin, Dey, Year)	ed cause of death (Item 2) PHA R 32. Registrer's, Signetu	0.,	BALT	imor	E, N	10 H	237
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/Medical	Emogene I 4a Facility Name (II not institution	redricka	Wi11:	iams	4h City Town or	Location of Death	4c. County	00 14	01
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thow the	10a. State 10b. County	1	10c. City, Town	or Location				10d. Inside C	City Limits
at, or items 23a or 28a-f show Exerciser must be notified at by Funeral Director		altimore	Woo	dlawn					2 NO
Dir	10e. Street and Number	"		10f. Zip Code			10g. Citizen of 1		
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eted	15. Decede	nt's Education	16a.	Decedent's Usual Occ	upation		16b. Kind of B	Black usiness/industry	
Completed	(Specify only higher Elamantary/Secondery (0-12)	College (1-4or to 2 vears	5+)	(Give kind of work dor lifa. DO NOT use reti Secret		orking	Baltim	ore Civic	League
BeC	17. Father's Nama (First, Middla	1 - 1			- 4	ama (First, Middle,			
ToB	Fred Archey				Elno	ra Loric	k		
	19a. Informant's Name/Ralation	ship <i>(Type, Print)</i> SiSt	ter 19b.	Mailing Address (Stre				, Stata, Zip Coda)	
other traumatic event, training	Addie Keys			08 Fairbro			altimor		44
50	20a. Method of Disposition 1 DaBurial 2 ☐ Cramation	3 □Ramoval from State		Disposition (Neme of y, crematory or other p		Date		- City or Town, State	
	4 Donation 5 Other (Specify)	Arbutu	s Memorial				re County,	
any Injury or other traumatic event, the Madical Exerca once. To Be Completed by F	21. Signature of Funeral Service	Enm			vnns Fall		neral n	omes, Inc.	
offeruse as the buriel-transit up to proper to the buriel-transit up to the buriel-transit up to the property of the buriel-transit up to the buri	Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last		Due to (or as a control of the contr	consequence of): A/L URE consequence of): SEP515 onsequence of):		ON, PENA	L ABSC.	10 DA 3-4 DA 14 DA ESS 14 DA	145
SICI	Part II. Other significant conditi	ons contributing to death b	out not resulting in	tha underlying cause	given in Part I.	23b. Dld	tobacco use co	ontribute to the cause	of death?
Phy	ATHEROSCLE	ROSIS, GE	WERAL	12E0	100	1 🗆	Yes 20 No	3 Probably 4	Unknown
page 2 should be detached for use a Completed by Physician/M	RENAL ART	ERY STEND			OPHY		an autopsy ormed?	24b. Wara autopsy available prior completion of of daath?	r to
omp	NEPHROSE					كلا	Yes 2□No	NYas 20	□ No
Be C	25. Was case referred to medic examiner?				26. Place of D	eath (Check only	ona)	1	
1 dip	1□ Yas No			tpatient 3 DOA		Homa 5 ☐ Resi			
led in by the funera Certification:	Z Accident	igation		rime of 28c. In V	njury at Vork? ☐ Yes 2 ☐ No		how injury occu		
Sertific	3 ☐ Suicide 6 ☐ Could detain	nined 259. Place of In	jury - At home, fa tc. (Specify)	rm, street, factory, offic	ca	28f. Location (City or To	Street end Num wn, Stete)	ber or Rurel Route Nu	mber,
To the Funeral Director: completely filled in by the Medical Certificat		ng Physician: To the best Examiner: On the basis o and manner st	f examination and						(s)
comp Me	29b. Signature and title of cartifi	0 - 1 1	_		ense number			ed (Month, Dey, Year)	
	0 00	n & Dicke	Ox	D	-1101		AllAll	- 11 M.	
	30. Name and address of person WILLIAM T. H.I. 31. Date filed (Month, Day, Year	ny wicke	N,00.		-0496	4	44643	11/20	00



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State of Maryland / Department of Health	and Mental Hygiene 🛭 🗎	26273
8 10/3/00 yf Certificate of Deat	th Reg. No.	-02,0
	2. Dete of Death Month Dey Year	3. Time of Deeth

Physician /Medical Examiner

Augustus Cleveland Woodard, III 4a Facility Nama (If not institution, giva street and number)

AUGUST 4b. City. Town, or Location of Deeth

14 2000 0705 4c. County of Deeth

Funeral Director

Usuel Residence of Decedent 10a. Stete

1. Decedent's Name (First, Middle, Last)

amend item 23a,pt.II 27 per me G78

Birthpleca (State or Foreign Country)

10d. Inside City Limits

Approximate Intervel Between Onset end Death

12 Yes 2 No

Herns 23s or 28s-f show the Medical Examiner must be "natural", or

Directo Funeral by Completed

filed within 72 hours after 2 should be and Mental h Pages 1 and 2 si ment of Health an . Department of Health Important: If Item 27.

Maryland 21215-0020

Baltimore,

Box 68760.

P.O.

of Vital Records,

Division

Physician /Medical Examiner

The lew requires that the death certificate be executed detached á 8 page 2 s or Attanding Physician: funeral director. this After after death.

Director: Aft
d in by the fur

1718 E. 12th 20e. Method of Disposition en Immediate Cause (Final diseese or condition resulting in deeth) Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Physician/Medical λq

10e. Street end Number Completed Be 25. Wes case reterred to medical examiner? examiner? Medical Certification: To

CARROLL COUNTY CENTRAL LAUNDRY CAMP SYKESVILLE CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sax 1 SM 2 □ F 5. Sociel Security Number 7. Age (In yrs. last birthdey) Deys Hours 212-50-1265 03/31/1952 10b. Count 10c. City, Town or Location MD N/A Baltimore 10f. Zip Code 10g. Citizen of Whet Country? Favette 21231 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give 1□ Yes 2 No Specify: Specify: Black If Yes, Give Yeer or Datas: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Laborer Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Augustus Cleveland Woodard, Jr. Lola Guess 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Martina Woodard/Daughter 1123 Comet Pl., Baltimore, MD 21201 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart Cemetery 08/22/00 Germantown, MD 22. Name end Address of Facility 21. Signature of Funerel Service Licensee Chavis Funeral Home, P.A., 2007-09 Eastern Av. Baltimore, MD 21231 - (410) 342-7400 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrast, shock, or have found to the cause on each line. MYOCARDIAL FIBROSIS Due to (or as e consequence of): Due to (or es e consequenca of): Due to (or as e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FOCAL ACUTE PANCREATITIS 24e. Wes en eutopsy

24b. Were autopsy findings available prior to complation of causa of death? 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signatura end title of certifiar

29c. License number O.C.M.E

29d. Date signed (Month, Dey, Year) AUGUST 14,2000

Mullinate 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 1Dey Days

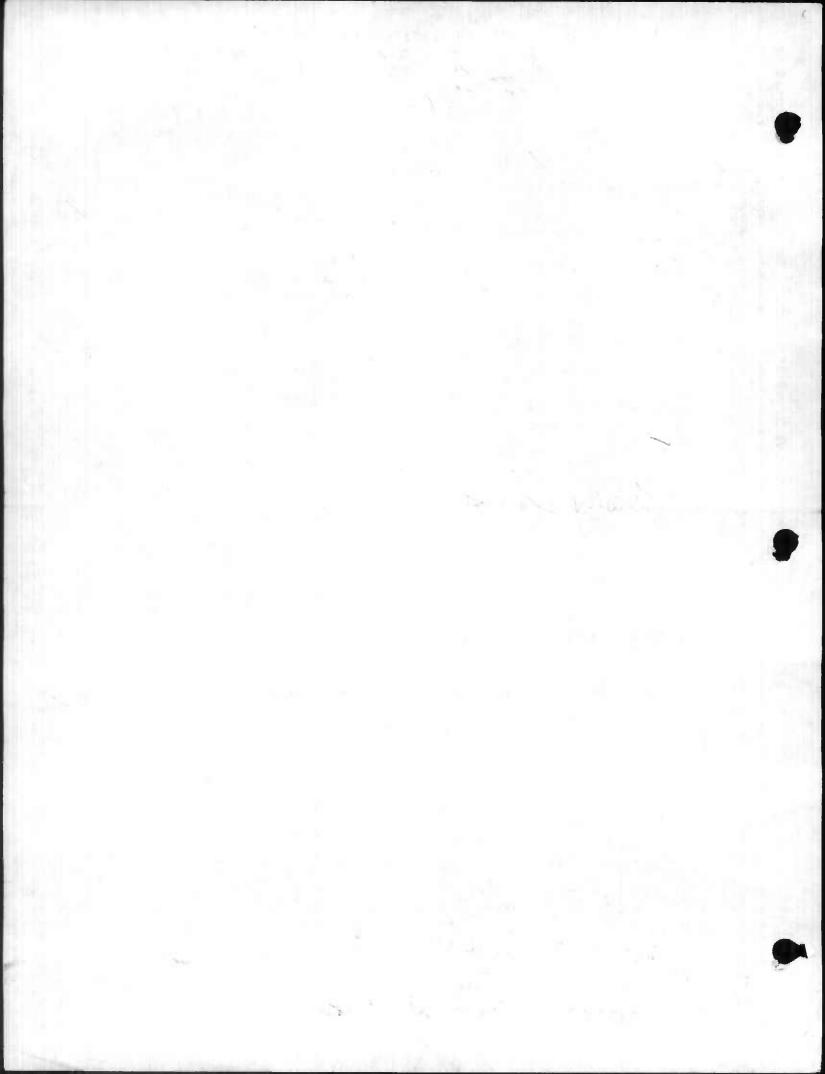
Registrar

completely filled in by

29e. Certifier

To the Hospital of within 24 hours at To the Funeral D

31. Data filed (Month, Dey, Year) AUG 1 8 2000 32. Aegistrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** ELVIRA ADDISON AUGUST 04 2000 0114 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENT & QUEEN ANNES HOSPITAL CHESTERTOWN If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 22 F Yes 68 Director 061-24-2503 Usual Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 M Yes 2 □ No NEW York Coty Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 36 Lower South Funeral ST. 10566 U.SA. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dalas: 1 Never Marriad 2 Merried Baltimore, Maryland 21215-0020 Specify: Black. 1 Yas 2 PNo Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECYETARY VETERANS administration 2 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth-any injury or other traumatic avam once. Be 2 HAZEL FORD CENTHOWN 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNSON - COUSIN F Ibur & O. Box 257 Chestertown, MD 21626 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Steta 20a. Melhod of Disposition Deta 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removal from State PITO/ CREMATORY 22. Name and Address of Facility 4 ☐ Donetion 5 ☐ Other (Specify) 8.5.00 DOVE 21. Signature of Funerel Service Licensee 23a. Perti Enier the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. P/127 FUNERA/ SERVICE CHESTERTOWN, MD21620 Approximete Intervel Between Onset and Death **Physician** 10 vers cular Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): P.O. Box 68760. Physician/Medical tha Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No signed b Records, þ page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 2 No 1 ☐ Yes 2 No 1 Yes certificata Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: After this certifica completaly filled in by the funeral director; p Be 25. Was casa referred to medical examiner? 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 30 DOA Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Magner of Death 28c. fnjury at Work? 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29e. Certifier (Check only one)

29b. Signature and title of pertifiq

32. Registrer's Signeture

1500

k2 Chestertown Mo 21620

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated.

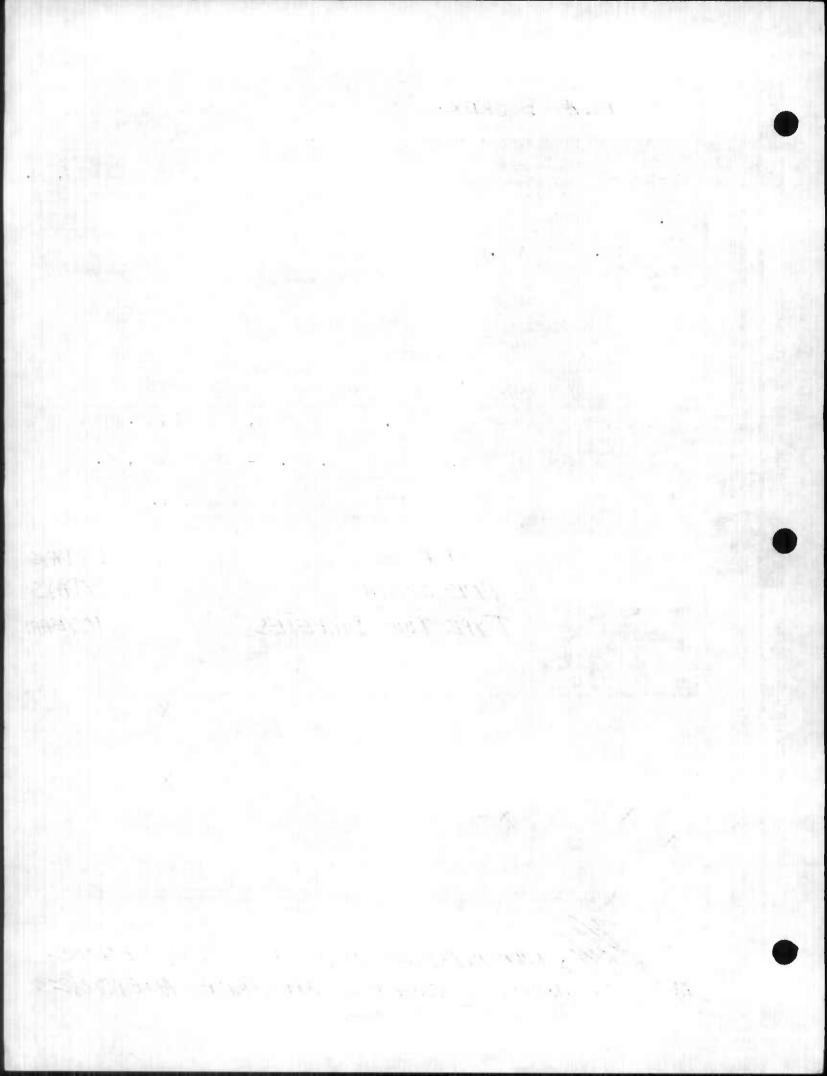
25 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

ate signed (Month, Day, Year)

20

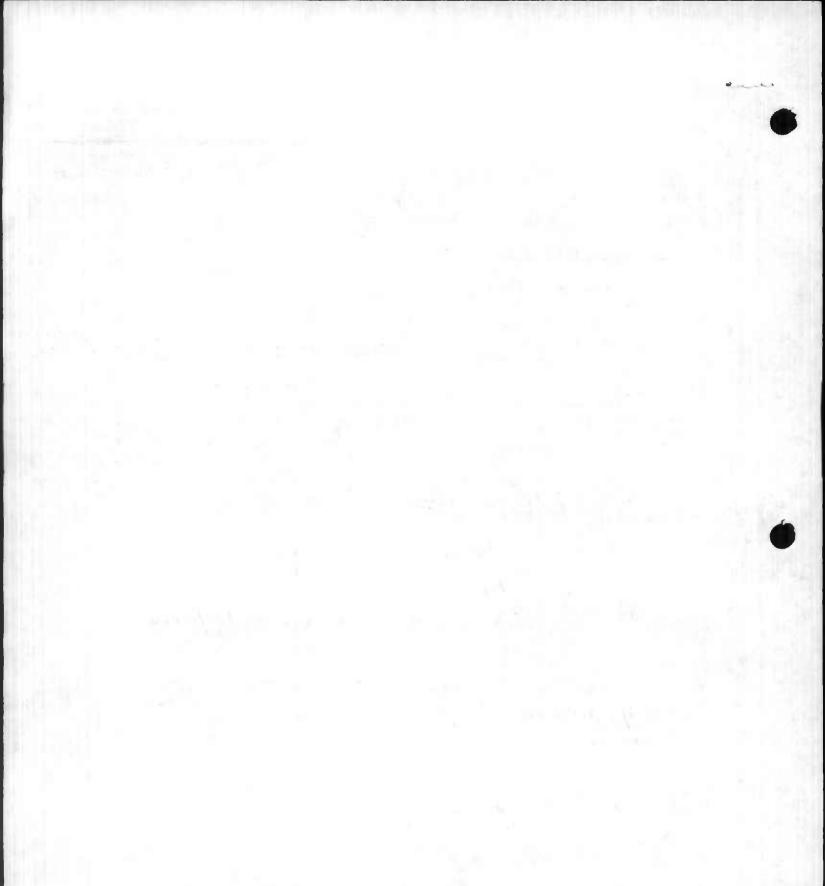
Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 26275

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aminer	4e Facility	Neme (If not institution	on, give street	t end number)			4	lb. City, Tow	m, or Local	tion of Deef	4c. Cour	nty of Death	
	PENI	ISULA REGI	ONAL M	EDICAL C	ENTER			SALIS	BURY		WIC	COMICO	
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-	-	lence of Decedent											
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Director	10e. Streef	and Number	3-1-1		31 1	10f. Z	ip Code				10g. Citizen o	of What Cour	ntry?
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by	3 Wid	owed 4 Divorce	d If	Yes, Give 'eer or Dates:		1 Yes	21X No	Specify:			Spec	BL	ACK
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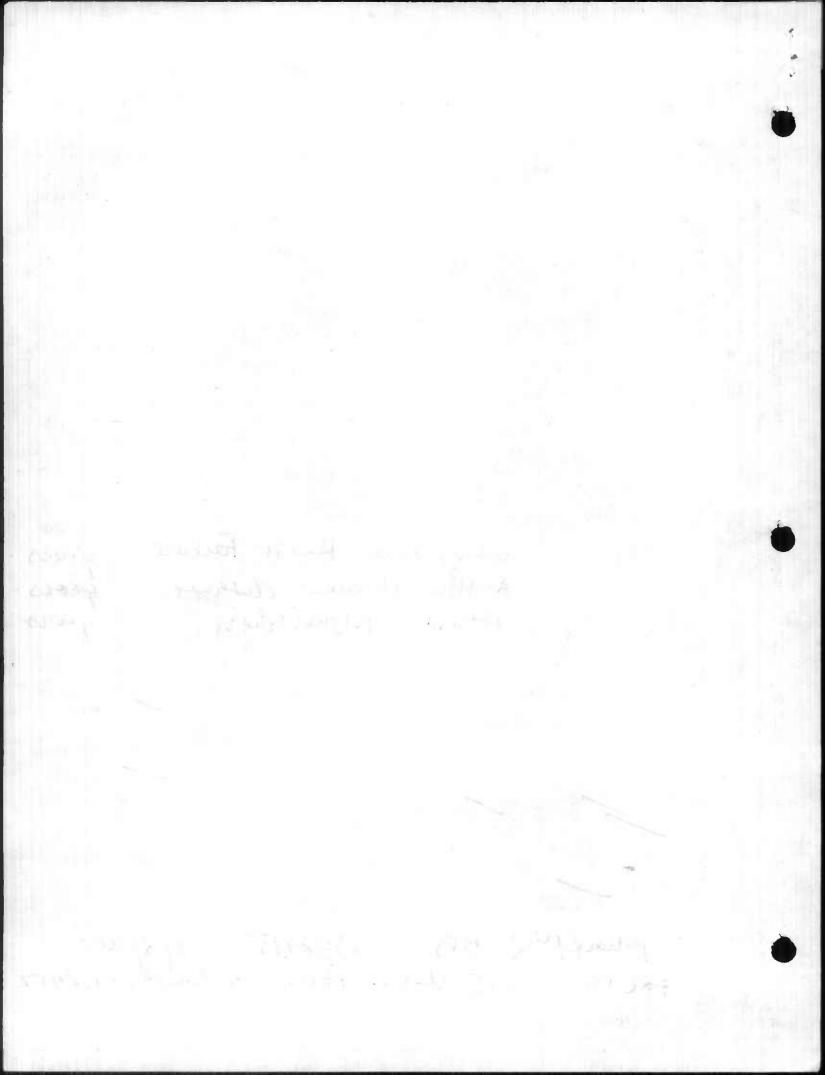
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

The control of the co	ician	1. Decedent's Name (First, M							2. Date of Month	Day	2000	3. Tima of Death 3:33 PA
DOCTORS COMMUNITY HOSPITAL Social Security Murbor 240-44-1118 1914: 30 F 70 yrs. Social Security Murbor 106. George 105. Cely, Town or Location 106. March 24, 1930 North Care 106. Cely, Town or Location 106. Security March 107. Security 107. Celego 107. Earl March 107. Security 108. Security 1					er)			4b. City, Town	or Location of D	eath 4c. Cour	ty of Death	
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22. Nama and Address of Facility E. M. DUDLEY E. M. DUDLEY E. M. DUDLEY E. M. DUDLEY FUNERAL HOME 2.00 E. M. DUDLEY FUNERAL HOME 3.200 RHODE ISLAND AVENUE MOUNT RAINIER, M. Approximate interval Bases as or complications finat caused the standard shock, or hard relative. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) Immediate Causa (Final disease or condition resulting in death) Immediate Causa (Final disease or condition resulting in death) Immediate Causa (Final disease or conditions as consequence of): Braun Lournard Due to (or as a consequence of): Braun Lournard Due to (or as a consequence of): Immediated events resulting in death) Last Due to (or as a consequence of): Thickensol Causa (Final disease or injury that indicated events resulting in death) Last Due to (or as a consequence of): 24a, Was an autopsy performed? 24b, Was an autopsy performed? 24c, Was an autopsy performed? 25c. Was case refarred to medical aranniar? 1 Yes 2 No 3 Probably 4 No No No No No No No		1 X Kurial 2 Cramati			ata				T1 25			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Items 10f, 19b per F.D State of Maryland / Department of Health and Mental Hygiene 08/08/2000, Carroll County, wil Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0545 05 2000 HARRY CLAGETT 0 CALVIN /Medical 4a Fscility Nsme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year 8. Dete of Birth (Month, Day, Year) Sep 29,1910 If Under 24 Hrs 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 15 M 2□ F 218-28-4326 89 Yrs Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Westminster t ☐ Yes 2€ No Directo Maryland Carroll 28a-f g g 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 250 Saint Lukes Circle 21157 21158 238 USA Funeral Barra 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. Nours after 1 ☐ Yas ⊉☐ No If Yes, Give 1 Never Married 2 Merried 8 altimore, Maryland 21215-0020 White 1 Yes 2 XNo Specify: Specify: À 3 Widowed 4 Divorced Yeer or Detas Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Suburban Propane Serviceman 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental John Adam Clagett Nellie Long 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a it if flam 27 is nor other train 250 Saint Lukes Cr, Westminster, Md 21157 21158 Mary Clagett, wife 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Hampstead Cemetery 8/8 Hampstead, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility M90723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervet Between Onset and Death Physician /Medical Immediete Cause (Final diseese or condition rasulting in deeth) Examiner Examiner that the death certificate be executed and Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician the burial Box 68760. Physician/Medical 88 for use signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 HW6 3 Probably 4 Unknown Records, Completed by The law requires 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? should completion of cause of death? page 2 1 Yes 2EH 1 ☐ Yes 2 ☐ No certificata of Vital Physician: 25. Was case referred to modical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division Attending 1 (Nature) 5 Panding 1 Yes 2 No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò Hospital 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of exa and menner steted. (Check only one) ninetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) within 2 120 29b. Signeture end title of certific 29d. Date signed (Month, Day, Year) 2000 30. Name and eddress of person who cause of death (Item 23s) (Type, Print) westwiste 15 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State AUG 0 8 2000 Registrar

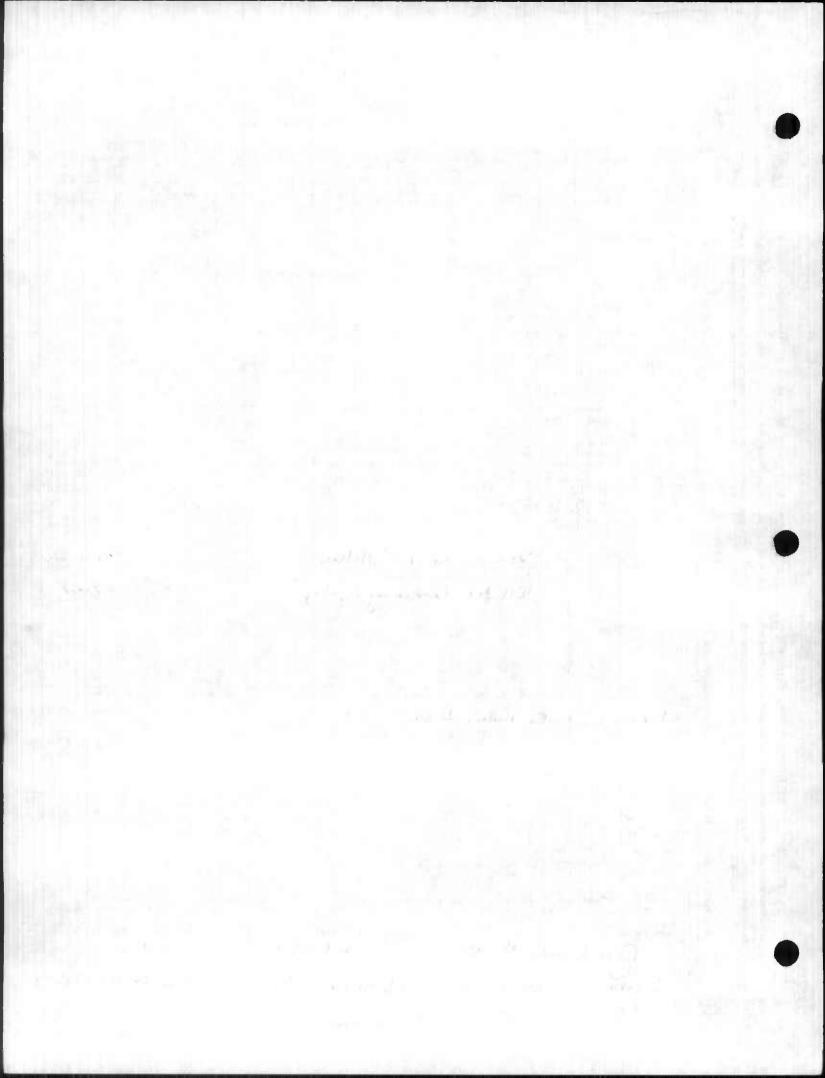


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day 2000 July 30, **Physician** KENNETH WAYNE CAREY 4:58 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 119 Liberty Way Fruitland Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F Yrs. 217-30-9992 65 Director Salisbury February 16,1935 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show ilene. r than "natural", or items 23s or 28s-f show the Hard cal Exerciser must be notified at 1 Yes 2 No Funeral Director Maryland Wicomico Fruitland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 119 Liberty Way 21826 USA death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Merital Stetus filed within 72 hours after It IXYes 2 No
If Yes Give Air Force 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. þ Specify: White 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Master Electrician Electric 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Peges 1 end 2 should be fill ment of Health and Mentel Hant: If item 27 is marked out William Mark Carev Minerva Wilson 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2: Department of Health at Important; if item 27 is any injury or other tracents. Robin Carey/Daughter 6005 Farming Ridge Blvd, Reading, PA 19606 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 🖺 Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Gardens 8/3/00 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee M01051 4. aved Dom one 23a. Pert1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abook, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediete Cause (Final Ventricilas disease or condition resulting in death) Examiner Years Physician/Medical Examine The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last as the bunal-tra-Box 68760. Due to (or as a consequence of): P.O. I Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed by page 2 should be detac Pulm. Chronii Olstrution Division of Vital Records. Py 24a. Was an autopsy 24b. Were autopsy findings Completed aveilable prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No hal or Attending Physician: The safer death.

al Director: After this cardificate ed in by the funeral director, pa 8 25. Was case refarred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 10 28c. tnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred edical Certification: 5 Pending Investigation 1 Neturet 1 Yas 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral C To the Hospita 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier My allenand your PJOPPO 8.1.00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) y PO2 SAUIBURY M 21804 32. Aegistrar's Signature JOSEAH CINDEREM 106 MILFORD 31. Date filed (Month L ON 2 2000 State

Registrar

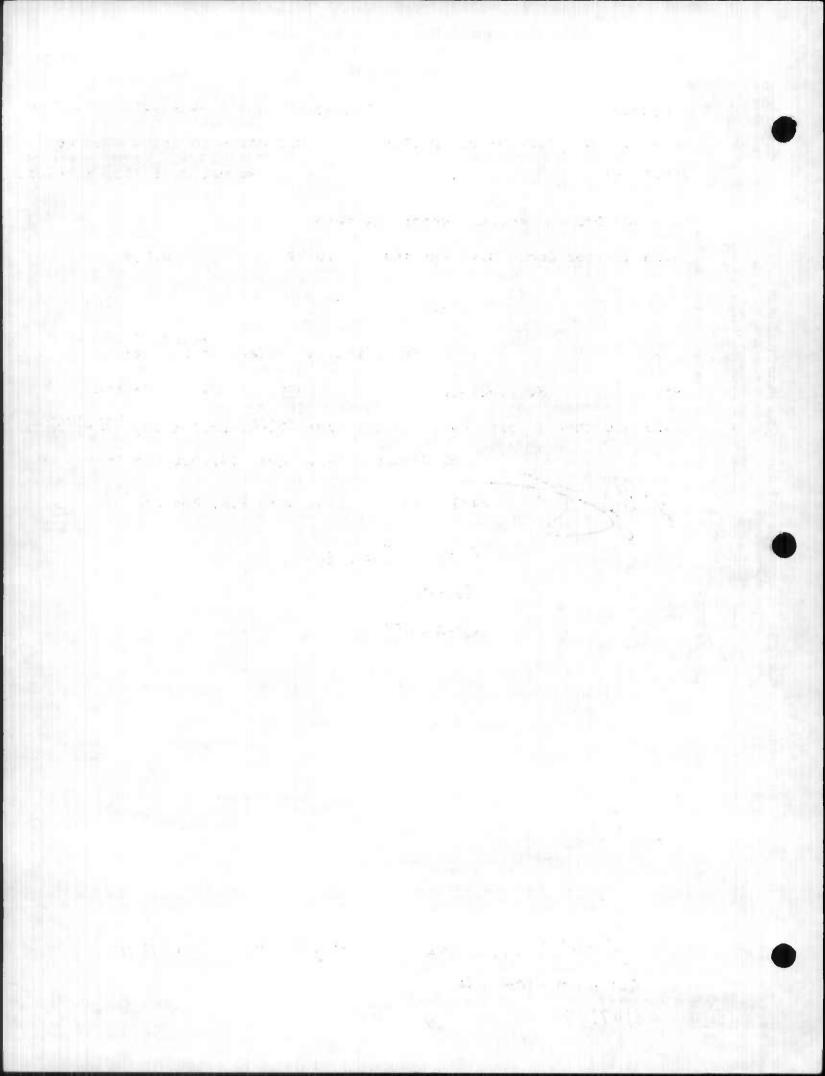


State of Maryland / D

Department of Health and Menta	l Hygiene	nn	26270	
Certificate of Death	Reg. No.	00	20213	

					C	ertifica	ate of	Death		Re	g. No.		- 0 50 1	
4.50		1. Decedent's Name (First, Middle, L	ast)							ate of Deet	h Day	Year	3. Time o	of Death
Physiciai /Medica		George		F.		Di	ucke	tt		gust	4 , 2	2000	1:00	pm (
Examine	_	te Facility Name (If not institution, g	ive street and nu	ımber)				4b. City, To	wn, or Location	of Deeth	4c. Cou	nty of Death	1	
	8	923 Heather Mo	ore B	lvd. A	pt.10) 4	1	Upper	Marl:	boro	Prin	ice G	eorge	es
Funeral	5	5. Social Security Number 6.	Sex	7. Age (In yrs	. last birthda	y) If Und	der 1 Year	If Under	24 Hrs. 8. Da Min. (N	ate of Birth	Year)	9. Birth	oplace (State	or Foreign
Director		17-36-9773 Usual Residence of Decedent	1₩ 2□ F	67	Yrs.				Nov	embe	r 11,	1932	Mary	land
filed within 72 hours after death with the Maryland Hygiene. Hygiene.	10a. State 10b. County Iaryland Prince	e Georg		ity, Town or pper		lbor	0					10d. Inside (City Limits s 2 No	
h the	Virector	10e. Street and Number				10f.	Zip Code			10	0g. Citizen	of What Cou	untry?	
1 wit		8923 Heather 1	Moore I	Blvd A	pt.10) 4	2	0772			U.S	.A		
deat	-	11. Meritel Stetus		pedent Ever in I			cedent of I	Hispanic Orig	gin? (Specify Y	es or No-		Race - Amer Black, White		
vurs after death with the Marylan al; or Neme 23a or 28a-f ehow Examine must be northed	6	1 ☐ Never Merrled 2 ☑ Marrled 3 ☐ Widowed 4 ☐ Divorced	Yes G	2 No			25 No		, a dello rilodi	, 610.7			ack	
natural',	Completed	15. Decedent's (Specify only highest g	Education rade completed))	16a. Dec	cedent's U	suel Occup work done	pation during most	t of working			Business/li		
d within piene. r than	Ē	Elementery/Secondary (0-12)	College	(1-4or 5+)								Geor		
filed within Hygiene. ther than than	3	12	-41		Tru	ick I	riv	1	Board					
d other	ď	17. Fether's Name (First, Middle, Las							r's Neme (Firs					
		Richard		uckett	1			Mary		E.		Vatso		
2 sho and is m		19a. Informant's Name/Reletionship	(Type, Print)		19b. Ma	iling Addre	ess (Stree	and Numbe	or or Rurel Rou	te Number,	City or To	vn, State, Z	ip Code)	
s 1 and 2 should f Health and Mer tem 27 is merke other traumatic	_	illian Ducket	t/ Wife	892	3 Hea	the	Mo	ore B	772 1vd.A	pt. 10	04 Ur	per	WATT	oro_
of Hez f Rem r othe	2	20e. Method of Disposition 1 Burial 2 □ Cremation 3	Removal from	200.	Plece of Dis cemetery, c	position (ASILIS OF		Da	te	20c. Locatio	on - City or T	Fown, State	
Pages nent of 1 ant: If its ury or o		4 □ Donation 5 □ Other (Spec		MD	Vete	erans	s Cei	m. Aug	rust 1	0,200	00 Ch	elte	nham	MD
permit. Pages of Pepartment of Pepartment of Pepartment: If its any Injury or of once.		21. Signature of Feneral Service Lio	insec)			22. Name	and Addre	ess of Facilit	У					
88 5 8		JU X	7	M191	αcδΛ	e Fi	mor	ם ו	me P.	7 7	~,,,,	2060	8	-52
		214 Part Enterthe disease, or bo shock or hard failure. List on	mplications that	ceused the dea	th. Do not e	enter the m	ode of dyl	ng, such es	cerdiac or resp	piretory erre	guasc est,	o ma	Approxima	ate
Physician		shock or high failure. List on	one ceuse on	each line.									Onset end	
/Medicai		Immediate Cause (Final		(1)		0-		~						
Examiner		disease or condition resulting in death)	6		Dn		nce					1		
	5			Due to	or as a cons	sequence o)i):							
executed in and iel-transit			b	Se	5112		Α.	-						
axecu and n	X	Sequentially list conditions, if eny, leading to immediate ceuse. Enter UnderlyIng Cause (Disease or Injury		Due to t	or es e cons	equence o	т):							
physician end s the buriel-transit		Cause (Disease or Injury that initiated events	c	Ju	Kope									
phys s the		resulting In death) Last		Dua to (or as a cons	equence o	f):							
ding ding ise a	3		d											
the death certificate be executed by the ettending physician end to the offer use as the buriel-transit	rnysiciary									no. Dida-			A - Ab	-4
t the d	ysi	Pert II. Other eignificant conditione	contributing to d	leath but not re	sulting in the	underlyln	g ceuse gi	ven in Pert I					to the cause	
										1 L Y	90 2□N	o 3 Pr	Obably 4 L	Unknow
heen signed been signed be should be deta	000								9	4a. Was a	n autonsv	24b. \	Were eutopsy	findings
requestion	000									parform	ned?	8	vailable prior	to
has b	Dataidillo										/		of deeth?	
en: The l	5									1□ Ye	s 2 D No) 1	I□Yes 2[□ No
clen: ector,	9	25. Was cese referred to medical exeminer?	11						of Death (Che	ock only on	Θ)			
yal dir	2	1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpat	ient 3	DUA		irsing Home	5 3 Reside	ence 6 🗆	Other (Spec	city)	
ding Ph h. After th funeral	5 2	27. Manner of Death 1 ☑ Netural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time fnjun		28c. fnju Wo	ry at ork?	28d. [Describe ho	ow injury oc	curred		
is after death. It Director: After the in by the funer.	8	2 Accident Investigati				М	1	Yes 2	No					
r Attend er death rector: by the		3 Suicide 6 Could not determine	d 28e. Plac	e of Injury - At I ling, etc. (Spec	nome, farm,	street, fact	tory, office			ocation (St		mber or Ru	ral Route Nu	mber,
rs after or led in led in	5						11/4							
within 24 hours after To the Funerel Dire completely filled in b	Gical	29a. Certifier 1 ☐ Cartifying F (Check only one) 2 ☐ Medical Ext	minar: On the b											(s)
within 2 To the comple		29b. Signature and title-pol capitiler	0				29c. Licen	se number		2	9d. Date sig	ned (Monti	h, Day, Year)	
- 5 - 0		D 4 4/2	him	a. 14.	0		DO	0520	999		081	0711	n	
		11. 170		au M		- P		002	117		0 3/	110		
	3	·	completed ceu		m 23e) (Typ	e, Print)								
			MIAN						-		è	-		
State	1	31. Date filed (Month, Day, Year)	32. 1	Registrar's Sigr	ature	ALIC	08	2000	Sener	ner	9.	Lon	Ka)	
Registra	r	08/07/00			11	AUG	000	_000	1		/	Jan Con	100	

DHMH 16 Rev 6/95



		State of the	viaryianu / i	Certificate	of Death		Reg. No.	26280
Share to London	1. Decedent's Name (First, Midd	la, Last)				2. Data of De	ath Day - 4	3. Time of Death
Physician /Medical	MAURICE	RAYMOND		DAVIS		0	7 Day 31	00 9:41 Am
Examiner	4a Facility Nama (If not Institution	n, giva straat and numbe	er)		4b. City, Town, or	r Location of Death	4c. County	of Death
	ATLANTIC GENER	AL HOSPITAL			BERLIN		WOR	CESTER
Funeral Director	5. Social Security Number 214–32–2008	6. Sax 1 → M 2 □ F	Aga (In yrs. last bi	rthday) If Undar 1 Months D	Yaar If Undar 24 Hr Days Hours Mir		th y, Year) 5,1930	Birthplace (Stata or Foreign Country) Maryland
p	Usual Residence of Decedant 10a. Stata 10b. County	,	10c. City, Tow	n or Location				10d. Inside City Limits
the Maryle 28a-f sho notified at rector		omico		sville				1 ☐ Yas 2 ♥ No
or 28a4 s be notified Director	10e. Street and Number	OMITCO	1100	10f. Zip Co	nda		10g. Citizan of W	hat Country?
1 08 0	34998 Poplar	Neck Rd			1850		USA	
ors after death v Fr. or thems 23s Standings must Sy Funeral	11. Marital Status 1 Nevar Married 2 Mar 3 Widowed 4 Divorced	If Yes Give	s?	13. Was Decedan If Yas, specify 1 ☐ Yas 2 ☑	it of Hispanic Origin? (Cuban, Maxican, Pua ≹No <i>Specify:</i>	Specify Yas or No rto Rican, atc.)	- 14. Race Black Specify:	- Amarican Indian, c, Whita, atc. White
be filed within 72 hours of other than "natura other than "natura event, the Medical E Be Completed i	(Specify only highs	nt's Education st grade completed)	16e	Decedent's Usual C (Giva kind of work of lifa. DO NOT usa i	Occupation dona during most of wi ratired)	orking	16b. Kind of Bus	siness/industry
y with journ the A	Elamantery/Secondary (0-12)	Collega (1-4c	or 5+)	Manager			Courie	er Service
i Hyg other ant,	17. Fathar's Nama (First, Middla,	Last)			18. Mothar's Na	ama (First, Middla,	Maidan Sumame)
Ments Ments arked affic ev	George W. D	avis			Mila	dred Sho	ockley	
ahou nama	19a. Informant's Name/Relations	ship (Type, Print)	198	o. Malling Addrass (S	Street and Numbar or F			Stata, Zip Code)
Selfe Transfer	Joan W. Davis	/Wife	3	34998 Popl	ar Neck Ro	., Pitts	ville, M	D 21850
Pages 1 a sett of He at: If Hern y or othe	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (S		cemate	of Disposition (Nama try, cramatory or othe Ville Ceme	r place)	Data 8/2/00		City or Town, State
auth certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Causa (Final disease or condition rasulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in deeth) Last	complications that cause only one cause on each	Que tollor as e Ulun Dia 1/2 (or as a Dua to (gras a	consequence of):	tenin	., Sallsi	oury, MD.	Approximete Interval Between Onsat and Death
e death he atten hed for u	Part II. Other ignificant condition	ons contributing to death	but not resulting	in the underlying caus	sa givan in Part I	23b. Did	tobacco use con	tribute to the cause of death?
and by the detached detached	Doloni					1 🗆	Yes 2□ No	3 Probably 4 dunknown
been sign should be leted by	Kepali	i usuf	lugy				an autopsy emed?	24b. Wara autopsy findings available prior to completion of cause of death?
eldian: The law certificate has rector, page 2 b Be Comp	Melista	ter Mo	stocto	Conce	ec	101	Yes 213No	1 ☐ Yes 2 ☐ No
E 25 B	25. Was case referred to medica examiner?	1	,			eath (Check only o	one)	
To To	1□Yes 2⊞No	Hospital: 1 El Inpa	tient 2 ER/O	utpatient 3D DOA	Other: 4 Nursing	Home 5□ Resi	dence 6 Othe	r (Specify)
ding Ph th. Atlantin tuneral	27. Manner of Death 1 ⊡Natural 5 □ Pendir 2 □ Accident investi		day Year) 28b.	Time of 28c. Injury M	Injury at Work?	28d. Describe	how injury occurre	d
To the Hospital or Attending Physici within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral director. Medical Certification: To E	3 Suicide 6 Could 4 Homicide determ	sined 286, Place of	injury - At home, fi etc. (Specify)	arm, street, factory, o	ffice	28f. Location (City or Tox	Street and Numbe en, State)	or or Rural Route Number,
n 24 hours n 24 hours ne Funeral pierely fille edical C		Physician: To the ber Examiner: On the beris	of examination ar					
Me Me	29b. Signature and title of certifie	1 //		29c. L	icense number	17	29d. Date signed	(Month, Day, Year)
	1	When	2	/	1-0040	221	7/2	1/00
you/	30. Name and address of porson	who completed cause of	death (Item 23a)	(Type, Print) D.B	Julio	Depen	AAAA	_
State	31. Date filed (Month, Day, Year)	AV 8002 5/1	trar's Signature	12/1	10116	NE	177/5	
Registrar	AUG 0 2	2000	neva 1	D. Spo	ch			

6447

7/31/00

Baltimore, Maryland 21215-0020

Davis, Maurice 2/5/30 214 32 2008 DOB 12/5/30 Division of Vital Records, P.O. Box 68760,

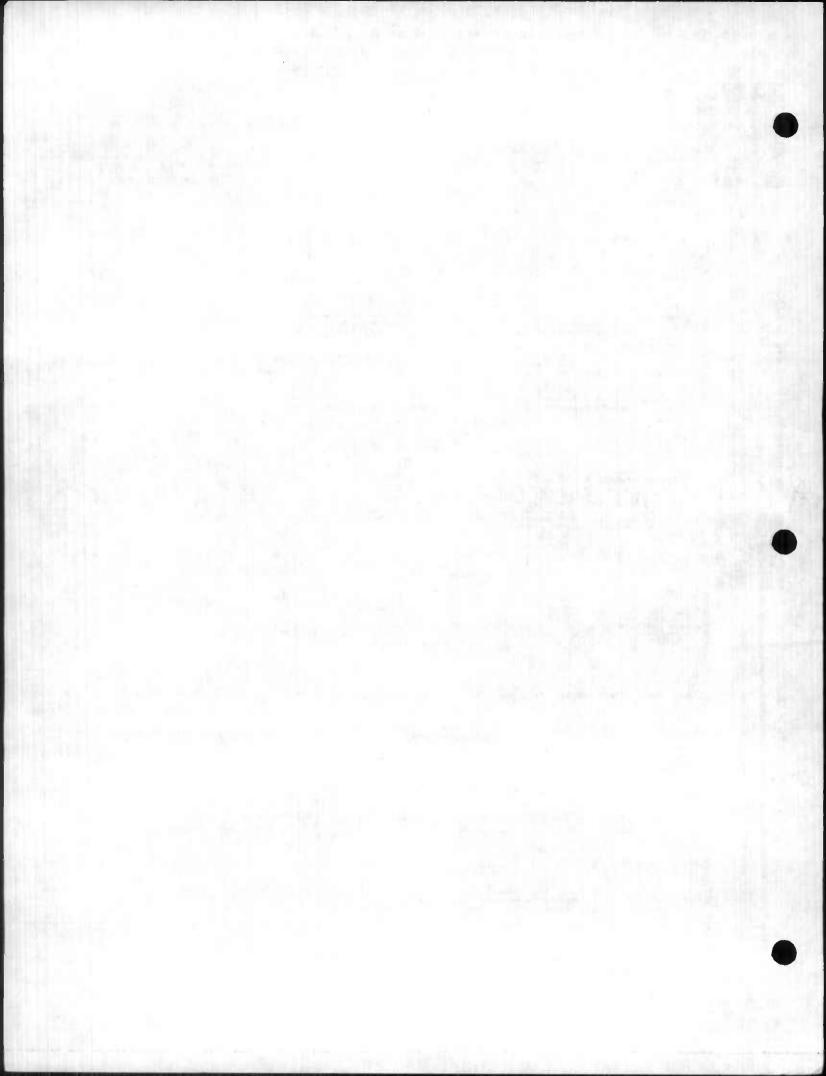
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State of Maryland / Department of Health and Mental Hygiene 00 2628 |

Mend item 27 per phys. G786 8/18/00 yg

Certificate of Death

amend it	em 27 per phys. G786 8/18/00 yg Certificate of Deatl	h Reg. No.	20201
	1. Decedent'a Neme (First, Middle, Last)	2. Data of Death Month Day Year	3. Tima ol Death
Physician /Medical	AGNES GUNNING DUKES	July 26,2000	0215
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, 1	Town, or Location of Death 4c. County of Dea	
	The Memorial Hospital Ea	aston Talbo	t
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Bir	thplace (State or Foreign ountry)
ector	220-26-1457 10 m 21XF 85 Yrs.	Mar. 23, 1915 Sc	otland
	Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
-	MD Campling Feder	alsburg	1 □XYes 2 □ No
oto			1
ai Director	10e. Street and Number 412-15 Liberty Road 21632	United St	
Funeral	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic C	Origin? (Specify Yas or No- tan, Puerto Rican, etc.) 14. Race - Ame	
2	1 3		Vhite
Completed	15. Decedent's Education 16a. Decedent's Usuel Occupation	16b. Ktnd of Business	/Industry
old	(Specify only highest grade completed) (Give kind of work dona during molifie. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+)	ost of working	Day Clara
E O	8 Laundress		Dry Clean.
umatic event, the To Be Co	17. Father's Name (First, Middle, Last)	her's Name (First, Middle, Meiden Sumeme)	
To	Francis Douglas	Martha O'Connell	
r treum		nber or Rurel Route Number, City or Town, State, Rd., Federalsburg	Zip Code) MD 21632
ette ette	20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place)	Dete 20c. Location - City or	Town, State
, o	11 Data 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Hill Crest Cemete	ry 7/29 Federalst	ourg, MD
inju	21 Signature of Europeal Services Licenses	ility	
eny	Michael 7. Eskon PO Box 43,	wkins-Eskow Funera Federalsburg, MD 2:	Home, PA 1632
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart feilure. List only one cause on each line.	as cardiac or respiretory arrest,	Approximate Interval Between Onset and Death
sician edical	Immediate Cause (Fine)		111.6
niner	disease or condition		7 days
-	Due to (or as a consequence of):	reatic cancer	
isl-transit Examiner	Metastatic Panc	reatic cancer	2 MONHS
-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		
			1
edical	resulting in death) Last Due to (or as a consequence of):		
use as	d		
for u			1
detached for use a y Physician/M	Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Par		
P. P.	00M	1 Yes 2 No 3 F	Probably 4 Unknown
		24a. Was en eutopsy 24b.	. Were autopsy findings
, page 2 should	Coconact Affeir diseas	performed?	Were autopsy findings available prior to completion of cause
ge 2 shoul	3COPD. @ Renal Insuff. cercy		ol death?
Com	BCOPP. (4) Repal In Suff. cency	1 ☐ Yas 2 ☐ No	1 Yes 2 No
Be (ace of Death (Check only one)	
.= 0		Nursing Home 5 ☐ Residence 6 ☐ Other (Sp.	ecity)
		28d. Describe how injury occurred	
e fune	1 Description 1 Description	□No	
d in by the fu	3 ☐ Suicide 4 ☐ Homtcide 6 ☐ Could not be determined 28e. Plece of Injury - At home, lerm, street, lactory, office building, etc. (Specify)	281. Location (Street and Number or F City or Town, State)	Rural Route Number,
led in by the funer Certification:	Building, etc. (v)pecky)		
completely filled in	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date	and place, end due to the cause(s) and mennar	is stated.
pletely fil edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, do and menner steled.	eem occurred at the time, date end placa, and du	ie to the cause(s)
N N	29b. Signature and title of curtifier 29c. License number	29d. Date signed (Mor	oth, Day, Year)
	1 9 30 DA NO DILLO	CC 07.26.	00
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)	66	00
	FITZARETH NECA MD 219 5. WA	SHINGTON ST, EAST	ON, MD21601
			,
State	31. Dete liled (Month, Day, Year) 32. Registrar's Signature		

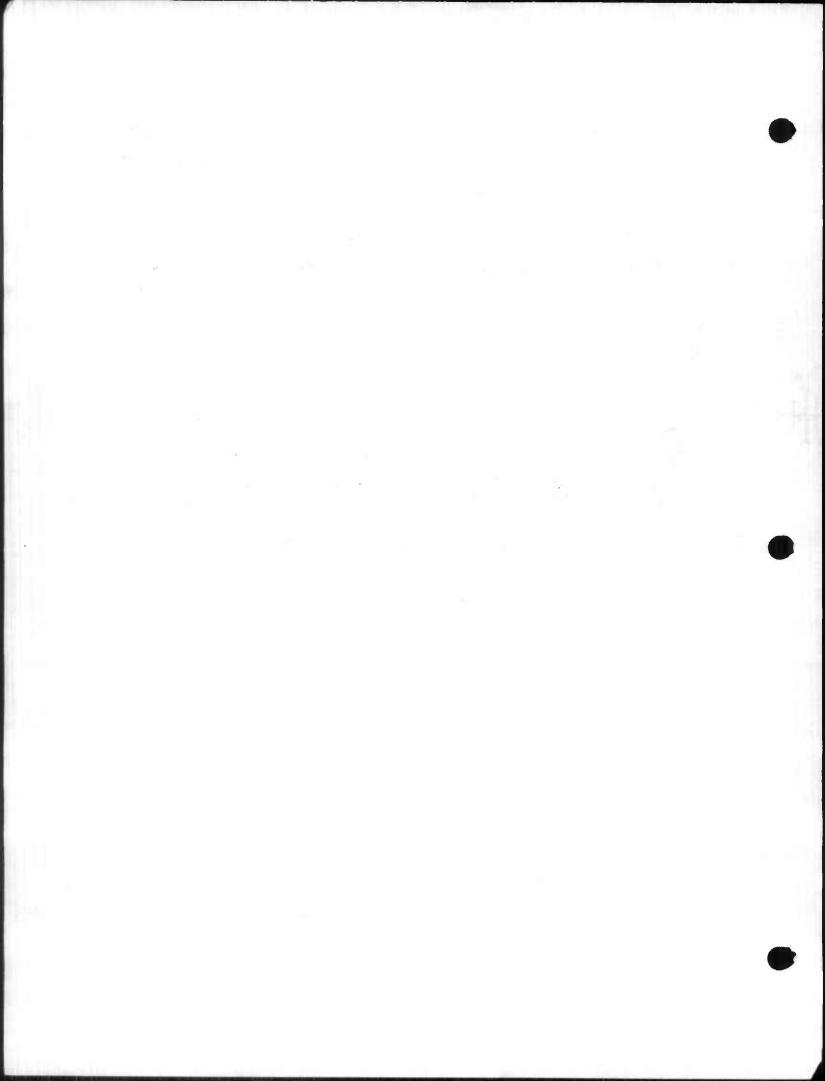


DHMH-16 Rev 1/89

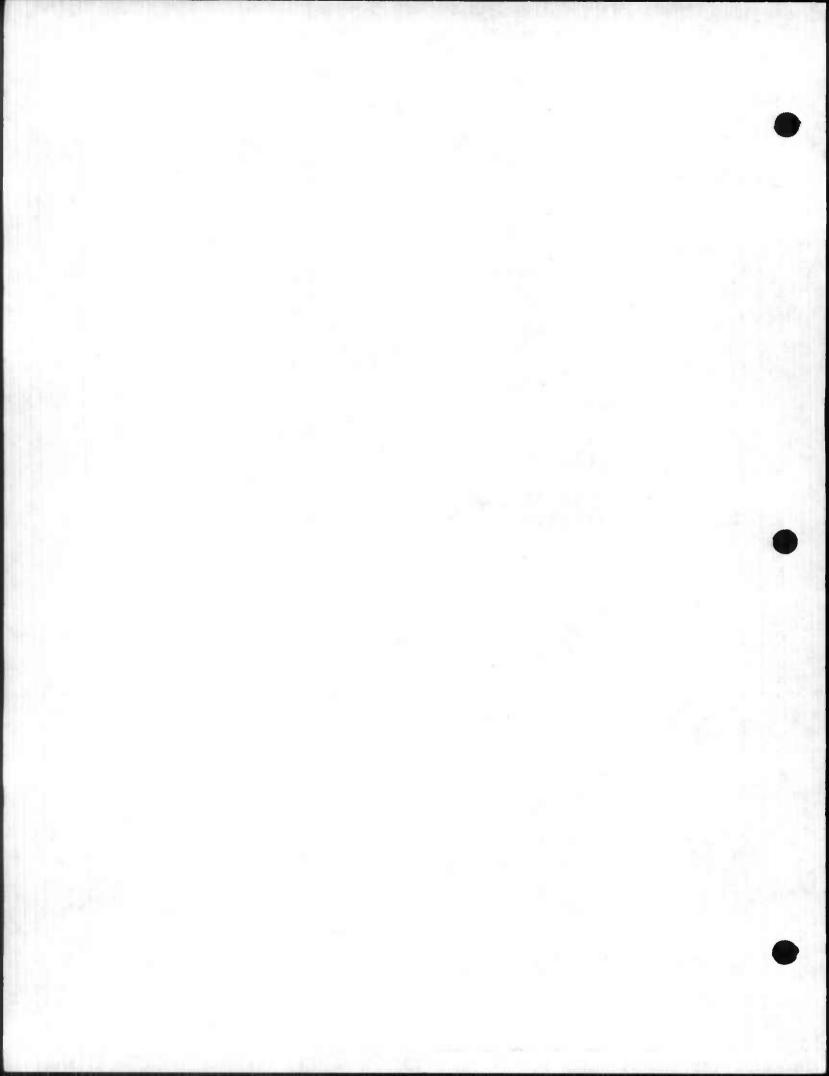
	1, 2, 3 should		
	Pages		
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	WE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	led within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal,	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE H	THE FU	filed wi	PORTA
2	2	20	Ξ

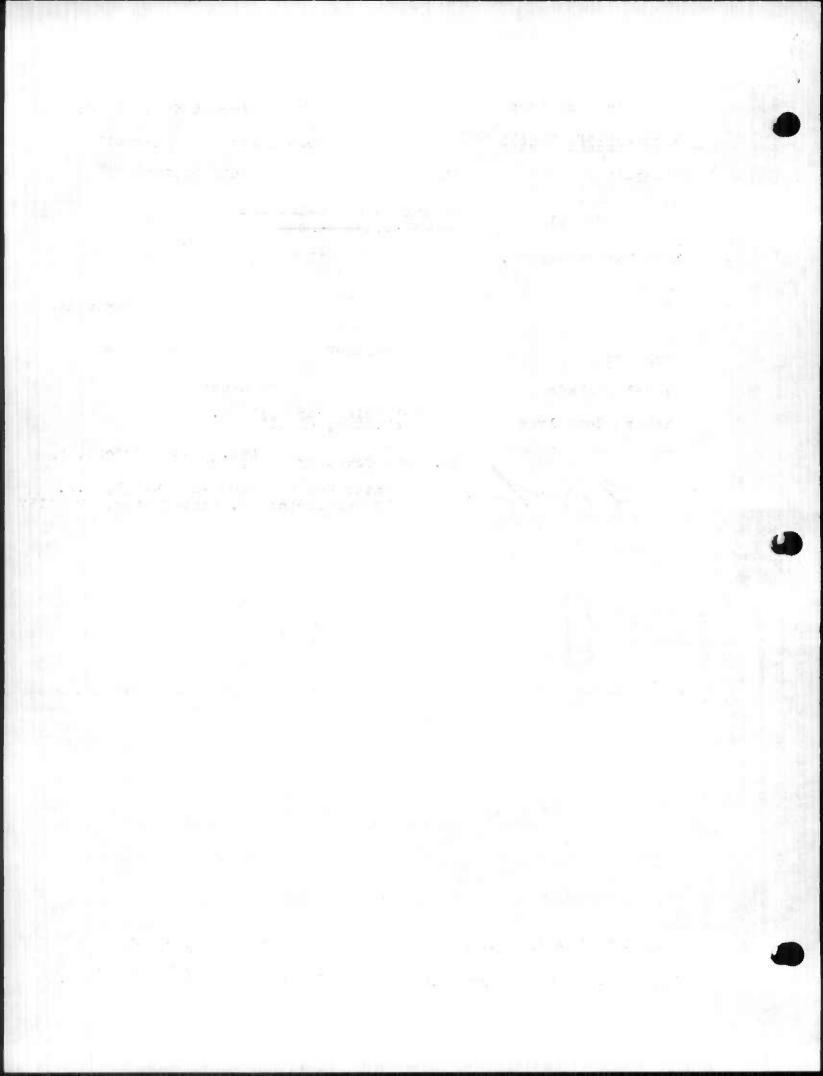
STATE OF	MARYLAND /	DEPARTMENT	OF H	EALTH AND	MENTAL	HYGIENE
	CE	RTIFICATE	OF	DEATH		REG. NO.

1 - STATE REGISTRAR	STATE OF MAR	YLAND / DEPARTI CERTIFIC	MENT OF HI		MENTAL HYGI REG.		
1. DECEDENT'S NAME (First, Middle, L.	St.	AGLS.			2. DATE OF DEATH	DAY	YEAR O 445 A
4. SOCIAL SECURITY NUMBER 212-46-2178 9a. FACILITY NAME (If not institution, g	1 M 2 □ F	52 YRS.	F UNDER 1 YEAR ONTHS DAYS	HOURS MIN,	7. DATE OF BIRTH (Month, Day, You Oct. 19,	1947	8. BIRTHPLACE (State or Foreign Country) West Virginia
Eastern Correct	ional Center		Princes				erset
10e. STATE 10b. CO			town or locate	DN ZIP CODE		100 01717	10d. INSIDE CITY LIMITS? 1 YES 3 NO EN OF WHAT COUNTRY?
2201 Old Westm	inster Pike			21048			ed States
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVEN FORCES? 1 YES, GIVE WAR O	ER IN U.S. ARMED ES 2 NO R DATES X		ify Cuban, Mexic	NIC ORIGIN? (Specify an, Puerto Ricari, etc. ly:		14. RACE — American Indian, Black, White, atc. Specify: White
15. DECEDENT'S (Specify only highest g Elementary/Secondary (0-12)	EDUCATION rade completed) College (1-4 or 5+)	18a. DECEDENT'S US (Give kind of wor life. Do NOT use	k done during mos		16b. KIND OF	BUSINESS/INDU	
17. FATNER'S NAME (First, Middle, Last,		Forklif	t Opera		Fa	den Surname)	
William Henry					e Mayle	,	
t9a. INFORMANT'S NAME (Type/Print)	Tm /				Floute Number, City or		
Ralph E. Eagle	, Jr/son	20b. PLACE AND DATE OF			urnie, MI		Olty or Town, State
ON Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE		cemetery, crematory or other Evergreen M	r place) [emorial		s 8/8 F		g, Maryland
23. PART I. Enter the diseases,	A Myer		Myers	Funera	1 Home	Jactmin	is Street
MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO COR	CED CHLO AS A CONSEQUENCE OF): AS A CONSEQUENCE OF): AS A CONSEQUENCE OF):	2 N	BSTRU	CTIVEP	MONA	Onset and Death MY PISEASE 710 1 YEAR 710 YES
PART II. Other algorificant cond	tions contributing to dear	th but not resulting in	tha underlying	cause given in	PEF	S AN AUTOPSY FORMED? S 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CO 25. WAS CASE REFERRED TO MEDICA		28. PLACE OF DEATH	(Check only one)	UNCERTA	IN 🗆		
EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/	Outpatient 3 DOA 4	OTHER:		, / -	PRIS	
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigat	26a. DATE OF INJU (Month, Day, Ye		RY WOF		28d. DESCRIBE H	OW INJURY OCC	URED
3 Suicide 6 Could no determine	ballding, etc.	PURY — At home, ferm, str (Specify)	eet, factory, office		28f. LOCATION (St City or Town, S		or Rural Route Number,
(Orlow Orly)	HYSICIAN: To the best of my l						ed.
296. SIGNATURE AND TITLE OF CERT	hug MI)		DOO	50826	10	8 05 2000
PAZAAIC.	A. ENIOLA	F DEATH (ITEM 27) (Type, F	420 PE	YELL'S M	leck PD	NESTO	VER MD 2180
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	D. C. Daniel and L. Daniel	Sperk				



			State of	Maryland		rtment of l tificate of	Health and Death	Mental Hy	rgiene (10 2	26283	
Physicia /Medic	_	1. Decedent's Name (First, Middle Walter	Decedent's Name (First, Middle, Last) Walter Perrine							te of Deeth Day Year 3. Time of Onth Day 2000 10:4		
Examine		4a Facility Nama (If not institution Howard County					4b. City, Town, or Columbia		4c. County of Death Howard County			
Funeral Director		5. Social Security Number 213–20–4531	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. le	st birthday) Yrs.	Months Days	The second secon	8. Date of 8i (Month, D NOV 2	8, 1924	9. Birthpla Country Mary	ce (State or Foreign	
020 urs after death with the Maryland sit, or items 23s or 28s-f show Exemper must be neuffed at	Funeral Director	10a. State 10b. County					10d. Inside					
		10e. Street and Number 10f. Zip Code 21042							10g. Citizen of Whet Country?			
	by Funera	11. Merital Status 1 Never Married 2 Merri 3 Widowed 4 Divorced	ed 1 X Yas 2			/es Decedent of Yes, specify Cut	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yas or N to Rican, etc.)		e - Americar ck, White, et	c.	
21215-0 within 72 ho ene. then "natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Gillite Elementary/Secondary (0.12) College (1.40r.54)				ent's Usuel Occu kind of work done O NOT use retire	during most of wo	rking	18b. Kind of 8usiness/Industry Professional			
bo file other dother avent	To Be C							other's Neme (First, Middle, Maiden Surneme) OSA Dell				
Md 2 in and 2 in an another 2 in another 2 in an another 2 in an another 2 in another		19e. Informent's Neme/Reletionsh Mrs. Gene A. Gr			3367F	North	chatham R					
Pages nent of mt: If h		20a. Method of Disposition 1 □ Burial 2 XCremation 4 □ Donetion 5 □ Other (Sp.		tete Alf	ce of Disposemetery, created Count	etion (Name of letory or other placy Crema	tion Serv	Data 7.8/6/20	20c. Location - 00 Sykes	City or Tow	m, State MD	
Balti permit. Departm Imports any inju			8. Haigh	~ ~	S	ykesvil.	NERAL HOM Le, MD 21	784 (41	0-795-14	(Box 00)	195)	
Physician /Medical Examiner	er	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Due to (or as a consequence of):									Approximate nitervet Between Onsat and Death	
the death certificate be executed the attending physician and ached for use as the burial-transit	/Medical Examiner	Ceuse (Disease or trijury that initiated events resulting in death) Last Dua to (or es a consequence of):										
P.O. Box 6 that the death certific ed by the attending I detached for use as	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of dea				
ds, P.O.	by Phy	Powerestre caraco					10	1 Yes 2 No 3 Probably 4 5 U				
Records, P	Certification: To Be Completed b							24a. We per	s an autopsy formed?	evail	e autopsy tindings tebte prior to pletion of cause eath?	
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VISION Of Attending Phys r death. ector: After this by the funeral di		25. Was case referred to medical exeminer? 1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pending investig 2 Accident 3 Suicide 6 Could n determine	28a. Date of (Month ot be 28e. Plece of	Injury , Day Year)	R/Outpetien 28b. Time of Injury	28c. Inju	ther: 4 Nursing I ury at ork?] Yes 2 No	28d. Describe	sidenca 6 Oth how injury occur (Street and Numb own, State)	red		
To the Hospital or within 24 hours after To the Funeral Director completely filled in	edicai C		Physician: To the beariner: On the basend menner	sis of examination								
To th withir To th comp	Me	29b. Signature and title of certifier Check Company Notions of P 3 70 13						29d. Dete signe	ey, Year)			
		30. Nama and address of person of Bruce M Conge	MD #2	of deeth (Item:	23a) (Type, I		tuxent 1		loubie	MO	21044	
Stat Registra		31. Date filed (Month, Dey, Yedr) AUG 0		gistrar's Signet	13	Spar	els				17.50	





State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** CLARA ODDO **GIARRUSSO** AUG. 2000 3:00 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CHESTERTOWN NURSING & REHABILITATION CTR CHESTERTOWN KENT 7. Age (In yrs. last birthday) If Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 10 M 2 F Months Hours 335-01-1011 98 Director MAY 26, ITALY Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at MD KENT CHESTERTOWN 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 8 200 WALTER DRIVE 21620 Norma 23a USA death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11 Marital Status Black, Whita, etc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 natural', or 1 Yes 2 Who Specify WHITE Specify: à 3 XXVidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nant of Haelth and Mental Hyglans. Int: If Itam 27 is marked other than ° Irry or other traumatic avent, the less Elementary/Secondary (0-12) College (1-4or 5+) -0-ASSEMBLY WORKER ELECTRIC SUPPLY CO. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ROSS ODDO ANTOINETTE DOMINO 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) SALVINA BENJAMIN/ 200 WALTER DRIVE, CHESTERTOWN, MD 21620 DAUGHTER 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete tXBurial 2 ☐ Cremetion 3 ☐ Removel from State permit. Paga Department o Important: If I any Injury or paga. RIDGEWOOD CEMETERY 8-7-00 DES PLAINES, IL 4 Donation 5 Other (Specify) 21. Signature of Funeral Se 22. Neme and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 Approximate Intervat Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) VENTRICULAR ARRHYTHMIA Zmin. Examiner Due to (or es a consequence of) Examine DRONARY ARTERY DISEASE 2 weeks physician and the burlai-transit The law requires that the death cartifloate be executed Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE þ Completed 24a. Wes an autopsy performed? Ware eutopsy findings available prior to ATWANCED AGE completion of cause of death? 1 Yes ale No 1 Yes 2 No of Vital or Attanding Physician: 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) To 1 Yes 2 No Other: Surring Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? After Accident Division 5 Pending investigation s after death. Il Director: Aft od in by the fur 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 □ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide Hospital 24 hours McCortifying Physician: To the best of niy knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) Whe 0041587 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG 4

HELEN A. NOBLE, M.D., 122 SPEER ROAD, CHESTERTOWN, MD 21620

32. Registrar's Signature

2000

AUG & BUA

State of Maryland / Department of Health and Mental Hygiene | |

26286 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 8, 2000 Betty Mae Glenn 7:00 p.m. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5865 Williams Street Rock Hall Kent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye January 14, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Deys Hours 1 M 2 TF 1926 Rock Hall, MD 74 Yrs. 220-26-3273 **Director** Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 No Yes 2 No Directo Maryland Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be n 5865 Williams Street 21661 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: by White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiona 8 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 2 should be n and Mental H is marked of Melvin L. Glenn Mary S. Kelley 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health: Patsy Higgs 5865 Williams Street, Rock Hall, Maryland 21661 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Dete Pages ment of h Important: If it any injury 1XX urial 2 Cremation 3 Removal from State Wesley Chapel Cemetery 8/11/2000 Rock Hall, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. el caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, approximate on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart tellure Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence ot) Physician/Medical Examiner nding physician and use as the bunal-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be axecu Box 68760, that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Medical Certification: To Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No one s tree of Vital Physician: 25. Was cese referred to medice! axaminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death
1 Anatural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred tnjury at Work? After Division or Attending 5 Pending investigation 1 Yes 2 No death. after death 3 ☐ Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Chestn from Md. 21620 5/6 Washington DUSAN K. 1855 mo 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 9

2000

DUG 8 5000

Physic /Medi Exami

Funeral Director

Physician /Medical Examiner

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effar death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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4e Facility Name (If not Institution, giva	street and number)				4b. City, To		ocation of Deat		ounty of Death		-
BERLIN NURSING & I	REHABILITAT	ION C	ENTER		BE	ERLIN		WC	RCESTE	R	
5. Social Security Number 6. Sec		yrs. last bi	rthday) If Under	r 1 Year Days		24 Hrs. Min.	8. Data of Bir (Month, Da	th V Year)	9. Birth	place (State o	Fo
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17. Father's Neme (First, Middle, Last)			JULI CLUI	1	18. Mothe	er's Neme	(First, Middle,			- ACCITEII	-
Walter G. Gibbon					Ma	rion	1	Gilpi	in		
19a. Informent's Neme/Relationship (Ty	rpe, Print)	198	o. Meiling Address	s (Street						p Code)	
C. Gilpin Gibbon/B			926 Lea								
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1 ☐ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)			ory, cremetory or			Ω	/3/00	Sal	isbury	MD	
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State

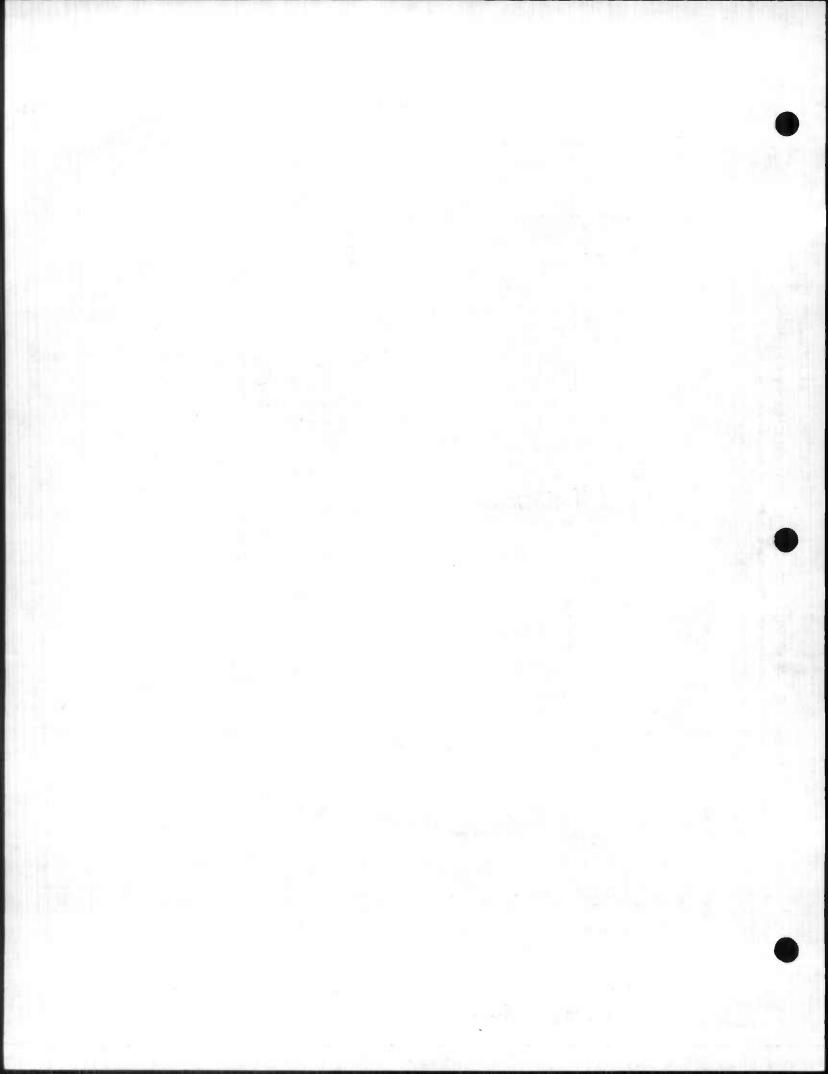
Registrar

31. Date filed (Month, Day, Year)

AUG 0 3 2000

Sparks

32. Registrer's Signeture

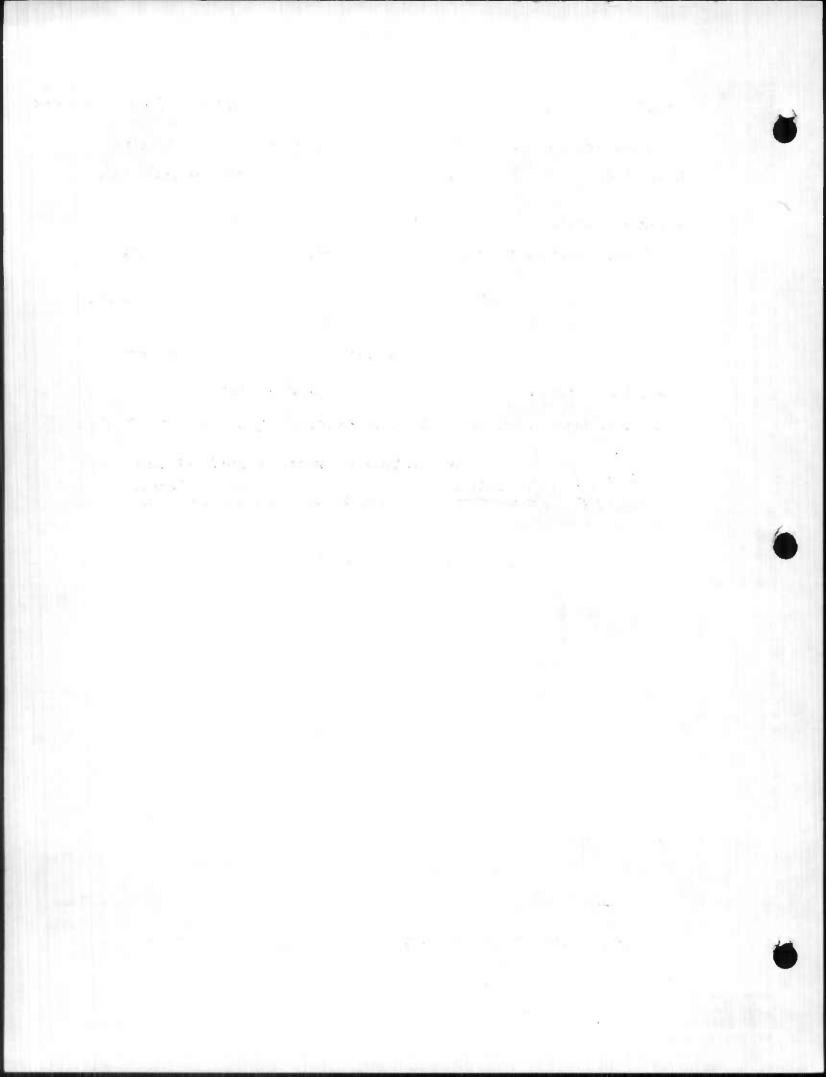


		State of Marylar		artment of			iene	26	288		
	Decedent's Neme (First, Middle, Last)						h	3	. Time of Earth		
Physician /Medicai		AUGUST	9 Day 200	O ^{Year} 5	5:20 PM						
Examiner	An Engiller Name III and Institution of	a street end number)	eet end number) 4b. Cify, Town, or L					4c. County of Deeth			
	6006 New Forest	Court Apt. 4	Waldorf Br Under 24 Hrs		Charles						
Funeral Director		Sex 7. Aga (In yrs.	(Month, Day,	Date of Birth (Month, Day, Year) AN 13, 1928 9. Birthplece (State or Fore Country) I OWa							
wo m	10e. Stete 10b. County	10c. Ci	ty, Town or L	ocation				10d.	Inside City Limits		
Man Han	Maryland Charles				1□ Yas 2□ No						
vith the Ma or 28s-f s be notified	10e. Street and Number		1	10g. Citizen of Whet Country?							
(h wi	6006 New Forest	Court Apt. 4		20	602		U	USA			
in 72 hours effer deeth with the Maryland in 72 hours effer deeth with the Maryland edited Exertine; must be notified at letted by Funeral Director		12. Was Decedant Ever in U Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates:	I,S. 13.	Was Decedant of If Yas, specify C	of Hispanic Origin? (Stuben, Mexican, Puar No Spacify:	Specify Yas or No- to Rican, etc.)	Blac	e - American I ck, Whife, atc. White			
72 hou	15. Decedent's E		16e. Dece	edent's Usual Oc	cupation	and a limina	16b. Kind of Bu	usiness/indust	iry		
d within 72 hours efgiene. Ir than "natural", or The Nedical Exert.	(Specify only highest gr. Elementery/Secondery (0-12)	College (1-4or 5+)		kind of work do DO NOT use rel	n Kany						
		1	Но	ousewife			Own He				
TTE A	17. Fethers Neme (First, Middle, Las				me (First, Middle, M	Aziden Sumeme)					
should be nd Mentel marked o umatic eve						na Schroder					
2 9 8 8	19e. Informent's Neme/Relationship				eet and Number or A						
A 40 MI L	Albert R. Hesso 20a. Method of Disposition	20b. I	Plece of Disp	osition (Neme of	est Ct. A		20c. Location -				
vermit. Peges 1 er Department of Hea mportant: If Item 2 nny Injury or other ance.	1 Buriel 2 Cremetion 3	Removal from State	cemetery, cre	ematory or other	plece)						
permit. Peges Department of Important: If i any Injury or ance.	4 Donavan 5 Other (Speci	1101		itan Cre		3-12-00	Alexand	ria, V	A		
permit. Departm Importar any Inju	N. 1/1 5	M00173				Eberwein					
	23a. Part. Enter the disease, or con	polications that caused the dea	fb. Do not er		ite Pls.				proximete ervel Between		
Physician /Medical Examiner permanage properties and permanage permanage properties and permanage per	Immediate Ceuse (Finel disease or condition resulting in death) Sequentielly list conditions, if env. leeding to immediate	b	or es e conse	equence of):	nt eli	Hash.					
ete be hysicia the bur	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): C. Due to (or as e consequence of): Due to (or as e consequence of):										
attending phi of for use es the		d									
death death he atte	Part II. Other significant conditions	23b. Did to	23b. Did tobacco use contributa to the causa of death								
res that the death certific rigned by the attending p be detached for use es by Physician/Mec							Yes 2 No 3 Probably 4 Unkno				
> 11 00 =						24a. Wes a perform	n autopsy med?	aveile	eutopsy findings ble prior to letion of cause ifh?		
F 20 0						1 🗆 Y	es a No	1 □ Y	as 2 No		
slan: entific ctor,		exeminer?					26. Piece of Death (Check only one)				
hysic his call dire	XYes 2□ No	Yes 2□ No Hospitel: 1□ Inpatient 2□ ER/Outpetient 3□ DOA Other: 4□ Nursin									
ding P. After t funera	27. Menner of Deeth 15. Neturei 5 Pending	ation M 1 Yes 2 No						red			
tal or Attending P is effer death. al Director: After ted in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined							oute Number,			
To the Hospital or Attending in 24 hours elter death. To the Funeral Director: After completely filled in by the funeral Medical Certification.		nysician: To the best of my knominer: On the bests of exemine and manner stafed.	owledge, dee etion end/or i	th occurred at the	e time, dete end plec ny opinion, deeth occ	e, end due to the courred et the time, d	euse(s) and mo	anner es state and due to the	d. e ceuse(s)		
To the within To the comp		29d. Data signed (Month, Day, Year) 8 - 10 - 2000 a									
	30. Name end address of person who	completed cause of deeth (item			MD 20	646					

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Yeer)
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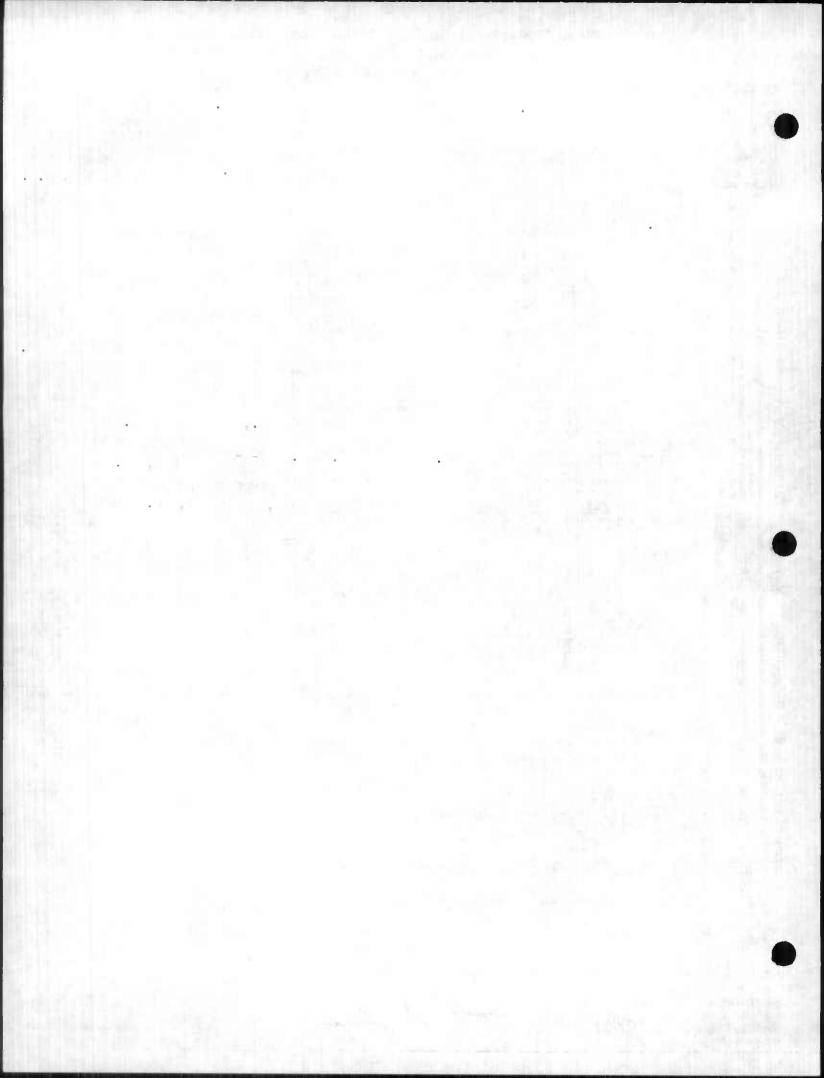
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 00 25289

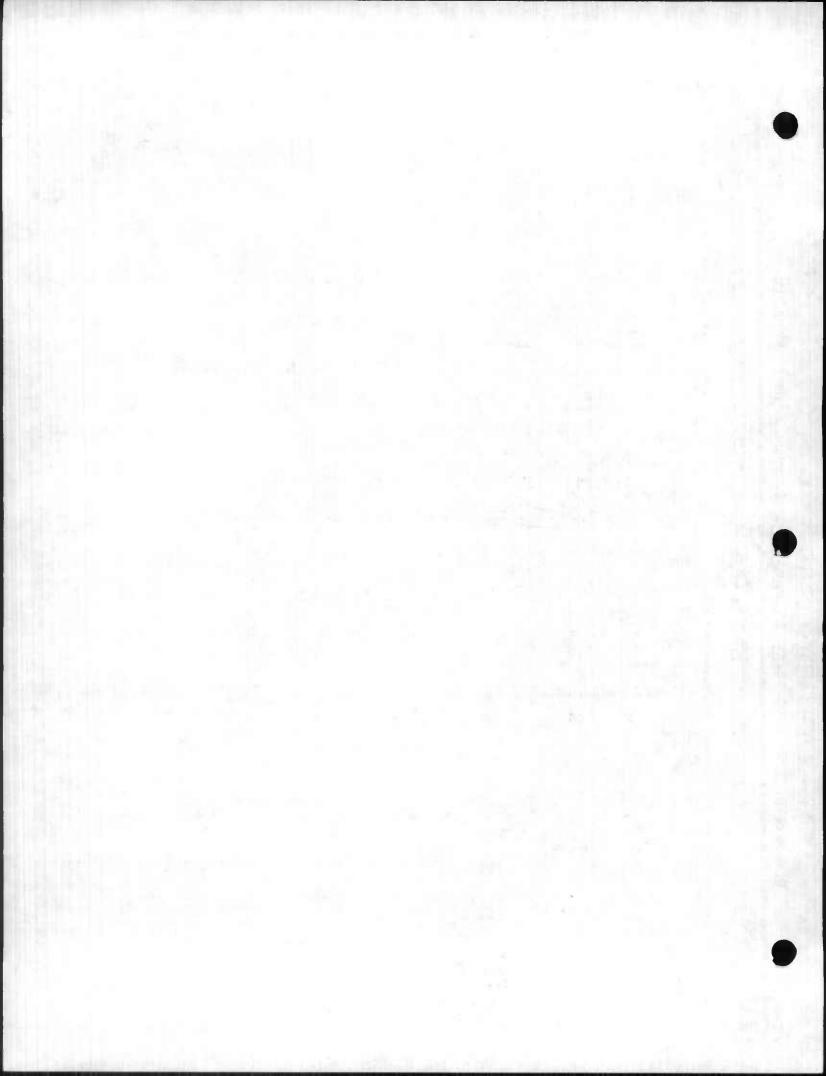
		Certificate of Death	Reg. No.
Physician /Medical	Decedent's Neme (First, Middle, Last) ROBERT L. HOPKINS		Date of Death Manth 28 2000 3. Time of Death 1026AM
Examiner	4a Facility Name (If not Institution, give street end number) ATLANTIC GENERAL HOSPITAL	4b. City, Town, or Locat BERLIN	ion of Death 4c. County of Death WORCESTER
uneral irector	241-04-2042	hday) If Under 1 Yeer If Under 24 Hrs. a. Months Deys Houra Min. Af	Dete of Birth (State or Foreign Country) 9. Birthplace (State or Foreign Country) 1. ittleton, N. (
fied at for	Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town MD WORCESTER BERL		10d. Inside City Limit 1 ☐ Yes 2 汉] N
Se or 28a-f self the notified	10e. Street and Number 10027 HUCKLEBERRY LANE	10f. Zip Code 21811	10g. Citizen of Whet Country? USA
raminer mu varriner mu by Funera	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give	13. Wes Decedent of Hispenic Origin? (Specify If Yes, specify Cuben, Mexican, Puerto Ric	y Yes or No- an, etc.) 14. Race - American Indien, Bteck, White, etc. Specify: BLACK
Completed	(Specify only highest grade completed) Flementery/Secondary (0.12) College (1.4or 5.4)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired)	16b. Kind of Business/Industry TRUCK DRIVER/CRANE 0
To Be C	17. Fether's Neme (First, Middle, Last) TOMMIE HOPKINS		First, Middle, Maiden Surneme) BETSY CARTER
r traumat		Meiting Address (Street end Number or Rural R 16 WOODLANDS GLEN RD.,	
ry or other	20e. Method of Disposition 1 A Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)	v. cremetory or other piece)	Dete 20c. Location - City or Town, Stete -2000 BERLIN, MD.
any inju	21. Signature of Fineral Service Licenses	22. Name and Address of Facility JOLL 1213 JERSEY ROAD, SA	EY MEMORIAL CHAPEL
cian	23a. Pert 1. En or the disease, or complications that casts of the deeth. Do n shock goneant failure. List only one cause on each line.	not enter the mode of dying, such as cardiec or re	espiretory errest, Approximate Interval Between Onset and Deeth
dical niner	Immediate Cause (Finel disease or condition resulting in death) Due to (or as e.g.	consequence of):	blimbs
edical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	my arten's di	feel years
the attending p thed for use as ysician/Me	d Part II. Other significant conditions contributing to death but not resulting in	the underlying ceuse given in Pert I.	23b. Did tobacco use contributs to the cause of deat
should be detacled by Physical	Districted	Vitel	1 Yes 2 No 3 Probably 4 Unkno
page 2 should			performed? svallable prior to completion of cause of death?
uneral director.	2 Accident investigation 3 Suicide 6 Could not be could not be	ime of 28c. injury at Work? M 1 Yes 2 No	5 ☐ Residence 6 ☐ Other (Specify) 1. Describe how injury occurred 1. Location (Street and Number or Rural Route Number,
completely filled in by Medical Certifi	4 Homicide building, etc. (Specify) 29e. Certifier no Certifying Physician: To the best of my knowledge,	, deeth occurred at the time, date and place, end	City or Town, State) I due to the ceuse(s) and mennar as stated.
completely filled in by the it	(Check only 2 Medical Examiner: On the basis of examinetion end and menner steted. 29b. Signeture and little of certifier	29c. License number	at the time, dete and plece, and due to the cause(s) 29d. Date signed (Month, Day, Year)
m	30. Name and address of person who completed ceuse of death (ttem 23e) (Type, Print)	SM ND 2(891
State	31. Date filed (Month, Day, Year) 32. Régistrer's Signeture	4 6	30,100

Robert Hopkins 241-64-2842



					Otato or i	viai yiai		ertificate o	f Death		Reg. No.	20	290
				1. Decedent's Name (First, Middle,	Last)	To the			40-12 114	2. Date of Dea	ith		3. Time of Death
M.		Physicia		William	М.		Jer	nkins		August	4,200	Year	16:50
		/Medic Examin		4a Facility Name (If not institution,	give street and numb	er)			4b. City, Town, or L	ocation of Death			10.50
		-Autimit	•1	Southern Mary	land Hos	nital			Clinton		Princ	e Geo	rges
		Funeral		5. Social Security Number		Aga (In yrs. I		lay) If Under 1 Yes	ar If Under 24 Hrs.				ce (State or Foreign
	L	Director		577-14-6656 Usual Rasidence of Decedent	11 M 2□F	90	Yrs	Months Day	rs Hours Min.	July 3	,1910	Maryl	and
		death with the Maryland ms 23s or 28s-1 show matter the mouting at		10a. State 10b. County		10c. City	y, Town o	Location			THE	10d.	. fnside City Limits
		the Maryle 28a-f sho	to	Maryland Cha	rles		Wald	dorf					1 No 2 No
-		h the M r 28a-1	100	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Country	?
U		h wit	Funeral Director	3515 Metro Gu	n Place			2060	1		U.S	. A	
+		hems h	ner	11. Marital Status	12. Was Decede	ent Ever in U,	S.		f Hispanic Orlgin? (Spuban, Mexican, Puerto	ecify Yes or No-	14. Rac	ca - American	
Pate	215-0020		by Fu	1 Nevar Married 2 Marrie 3 Widowed 4 Divorced		20No		1 □ Yes 2 N		r nour, oto.,	Specify		
-	0	2 hor		15. Decedent's	Education		16a. De	ecedent's Usual Occ	cupation		16b. Kind of B		
N	215	hin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	Gollege (1-4	or 5+)	(G	ive kind of work dor le. DO NOT use reti	cupation ne during most of work ired)	cing			
	2	filed with Hygiene. ther ther	Ö	12			S	killed I	abor		Const	ructi	on
	Maryland	be filed ntal Hygi of other avent,	Be (17. Father's Name (First, Middle, L.	ast)				18. Mother's Nam	e (First, Middle,	Meiden Suman	10)	
9	yla	Mentai Mentai arked o	2	Unknow	n				Alice		Jenki	ns	
0	lar	and and and and and		19a. Informant's Name/Relationshi	p (Type, Print)		19b. M	ailing Address (Stre	et end Number or Ru	rai Route Numbe	r, City or Town,	State, Zip Co	ode)
-		D = 22		Virgie L.Jenk	ins /Wi	fe 35	15 1	Metro Gu	n Place	Waldor	f Mary	land	20601
7	altimore,	8 4 5 0		20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3	Removal from Sta	20b. Pi	lace of Di ametery,	isposition (Name of crematory or other p	olaca)	Date	20c. Location -	City or Town	, Stete
-	E	Peges ment of ant: If Na ury or o		4 Donation 5 Other (Spe		St	.Pe	ters Cem	. August	11,20	00 Wal	dorf	MD
0	a	permit. Page Department of Important: If any injury or phose.		21. Signature of Funeral Sarvice Li	X 1		1 31	22. Nama and Add					
	8	80 E 9 8		23a. Part1. Enter the disease of cashock, or heart failure.	ZX	M191	A	dams Fun	eral Hom	O D A	Aguasc	o MD	20608
0	9			23a. Part1. Enter the disease of o	omplications that cau	sed the death	n. Do not	enter the mode of d	lying, such as cardiac	or respiratory ar	rest,	A	pproximate iterval Between
S		Physician										0	Inset and Death
9	40	/Medical		fmmediate Cause (Final disease or condition	V	ENTRIC	CULA	R FIB	RILLA TIO	V			
-	в	Examiner		resulting in death)	a.			nsequence of):			V 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	
0)		D #	edicai Examiner	Trees.	Myo	CARDI	IAZ	INFAR	CTION				
0		and -tran	хаш	Sequentially list conditions,				sequence of):					
C	60,	cien cien	E E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c								
2	68760,	ficate be asscuted physicien and is the burief-transit	dica	that initiated events resulting in death) Last		Dua to (or	r as a con	sequanca of):					
0		nding p	- 20		d				200				
-	Вох	attendin for use	lan									İ	
	o	the de	ysic	Part If. Other significant condition	s contributing to deat	h but not resu	ulting in th	e underlying cause	given in Part I.	23b. Dld 1	obacco una co	ntributa to th	na cause of death?
-	0	law requires that the death certificate be assocrted as been signed by the attending physicien and 2 Should be detached for use as the bunal-transit	by Physician/M	THIRD DEG	REE H	EART	15	LOCK		101	ras 2 No	3 Probab	bly 48 Unknown
~~	rds,	signed d be del	d b			4,7,5				24a Was	an autopsy	24b. Were	autopsy findings
50	ō	aw requires to been si	ete							perlo	med?	availe	abla prior to pletion of causa
-	Reco	has law	dm		3 000							of dea	ath?
1	al	: The cate h	Be Completed							101	es 2,25No	1 🗆 Y	res 28 No
7	Vital	Physician: The lav this certificate has rel director, page 2	Be	25. Wes case referred to medical examiner?	Hospitel:				26. Place of Dee				
0	o	Sic D	- To	1 ☐ Yas 25KNo 27. Menner of Death	1 Inp		ER/Outpa 28b. Tim	Itlent 3LI DUA	4 U Nursing H	ome 5 Resident			
Jer	uc	After	5	1 ⊠Natural 5 ☐ Pending	(Month,	Day Year)	Inju	ry V	Vork? ☐ Yes 2 ☐ No	200. 000011001	iow injury occor	160	
J	isi	Attending or death.	ca	3 ☐ Suicide 6 ☐ Could no	t be	Injuny . At ho	me ferm	, street, factory, offic		28f. Location (S	Street and Numl	her or Rural F	Pouta Number
	Division	i or Attend after death Director: d in by the	T e	4 Homicide determin	building,	etc. (Specify	/)	, street, ractory, orne		City or Tov	n, Stete)	70. 0. 1.0.0.1	Today Trumbur,
		To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai Certification:	29a. Certifier 154 Certifying	Physician: To the he	set of my know	wladna d	eeth occurred at the	time, date and placa	and due to the	rausa(s) and m	enner as state	ed
		Fun Fun etely	de	(Check only 2 Medical E	eminer: On the basis	s of examinat	tion and/o	r investigation, in m	y opinion, death occu	rred at the time,	date and place,	and due to th	na cause(s)
		ithin of the	Me	29b. Signature and title of my line	1	0.000		29c. Lice	ensa number		29d. Qata signa	d (Month, Da	ıy, Year)
-		F 3 F 8		· / V	2 Ms			D	53885			000	
			-	20 Name and olders of O		d decti (t)	00-1		7000				
				30. Name and address of person w	7-		UMA		# 307	CLINTO	w M	b 20	735
		Stat	0	31. Date filed (Month, Day, Year)		istrar's Signat	tura	, ,		CD(1V 10	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		
		Stat Registra			8 2000	Seper	a	19. pp	all				

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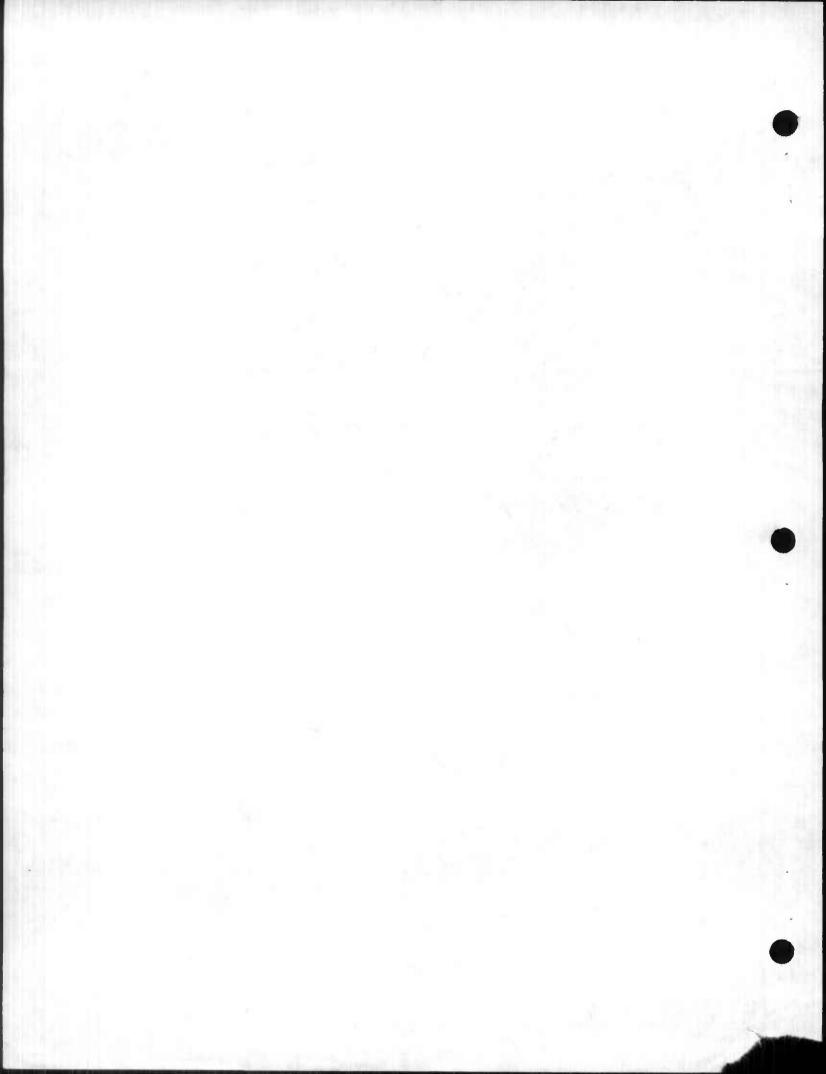


State of Maryland / Department of Health and Mental Hygiene 00 26291

				Ce	ntificate of	Death		Reg. No.		
	Physician	1. Decedent's Name (First, Middle, La Marie Antonie		ı			2. Data of Do Month August	Day	Yaar 000	3. Time of Death
	/Medical Examiner	4a Facility Nama (If not institution, given The Kent & Qu		Hospital		4b. City, Town, or Cheste	Location of Dea	th 4c. County	of Deeth	1930
41	Funeral Director	5. Social Security Number 6. 5		(In yrs. last birthday) Yrs.			s. 8. Date of Bi		9. Birthp Coun	lece (Stata or Foreign try)
	3	Usual Rasidence of Decedant					ререво	1.2.2.		
	a or 28a-t show be notified at Director	MD 10b. County Kent		Chesterto					1	0d. Inside City Limits 1 Yes 2 No
	23a or 28a-f s ust be notified	10e. Street and Number 415 Morgnec Road	d		10f. Zip Code 21620			10g. Citizen of V		try?
	ir, or hems 23 caminer must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Specify Yas or Norto Rican, etc.)	o- 14. Rac Bled Specify	k, White,	an Indian, etc. .ack
	outure dical	15. Decedent's E (Specify only highest gr	ducation ade completad)	16a. Dece (Giva	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	orking	16b. Kind of Bu		
	ygiene. At the Medical. Completed	Elementary/Secondary (0-12) 8th	College (1-4or 54) """	Domesti	.c	14.3	Privat		illies
	Aental H fice even fice even	17. Father's Name (First, Middle, Last James A. Jol					et Grav	e, Maiden Sumam BS	(e)	
2004	27 is me	19a. Informent's Name/Relationship (Marian Johnson –			ng Address (Street West Mad					Code)
	and of He rit: If Nem ry or othe	20e. Method of Disposition 1			osition (Name of matory or other pla L Cemeter		Date 8-14-00	20c. Location -		
	Departra Importa any inju	21. Signature of Funeral Service Lice	nsee	2:	2. Name and Addre	ass of Facility	ames A.	Perkins	Fune	ral Service Rock Hall,
	ding physician and se as the burief-fransit	Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last	b	Que to for es a consecue to (or es a consecue) to (or es a consecue to (or es a consecue to (or es a consecue)))).	quance of):	Paeun	omà			Onset and Death Z Weeks
	for u	Part II. Other significant conditions	contributing to death but	not resulting in the u	ınderiying cause gi	ven in Part I.	23b. Dio	I tobacco usa co	ntributs to	the cause of death?
		DCHE 0	Chronic	è Reva	l Fai	lune.	10	Y88 212 No	3 Prof	bably 4 Unknown
	2 should	3 Grastion	Chronic	blees	ep.			s en eutopsy lormed?	av co	ere eutopsy findings ailable prior to mpletion of cause death?
	page Com	& old CVA						Yes 2 140	10	Yes 2 No
	5 0	25. Was case referred to medical examiner? 1 Yes 21 No	Hospital: 1 12 Inpatien	t 2 ER/Outpatie	nt 3 DOA Ot	her:	eath (Check only Home 5 ☐ Res	one) sidence 6 □Oth	er (Specif	y)
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	27. Manner of Deeth 1 Draturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo	ry at ork?] Yas 2 □ No	28d. Dascribe	how injury occur	red	
	within 24 hours after death. To the Funeral Director: After tompletely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, st ('Specify)	reet, fectory, office			(Street and Numb own, State)	er or Rure	I Route Number,
1	n 24 hour he Funer pletely fill	29a. Certifier 1 Certifying PI (Check only one)	hysician: To the best of miner: On the basis of and manner stet	examinetion and/or to	h occurred at the ti vestigation, in my	ime, date end pled opinion, deeth occ	ce, and due to the curred at the time	cause(s) and ma , date and place,	anner as s and due to	tated. the cause(s)
	To the comp	29b. Signeture and title of certifier	lem, M	D.	29c. Licen	2/3/_	3	29d. Date signe	d (Month,	Day, Year)
		30. Name and address of person who	completed cause of de	- 15	Print	Aug	, Clus	tertour	r,n	1721620
	State	31. Date filed (Month, Day, Year)	32. Registre	's Signature	0		*			

Dhugiaian	1. 0		(First, Middla, Las	State of Ma PART I, 27		06	Tanoate of	Dodin	2. Data of Dea	ith	3. Time of De
Physician /Medical Examiner	I			cowski Sr. a street and number)				4b. City, Town, or L	AUGUST ocation of Death	12, 200 4c. County (
LXammer		05 1st s	STREET					RIDGELY		CAROL	TNF.
Funeral Director	2	ocial Security No. 12-42-3 all Residence of	841	ex 7. Ag	e (In yrs. la 55	est birthday Yrs.	If Undar 1 Yaar Months Days	if Undar 24 Hrs. Hours Min.	8. Data of Birtl (Month, Day Jan 5, 1	v, Year)	9. Birthplaca (Stata or F Country) Maryland
Herra 23a or 23a-f show oer must be notified at tuneral Director	10a	Stata	10b. County Caroline			Town or L					10d. Insida City I
or 28a-fr	100	Street and Nun				-8	10f. Zip Coda			10g. Citizen of W	hat Country?
nut nut		Maryla	nd Ave		11.0	140	2166		- cife Man an Na	USA	- Amarican Indian,
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ental H and oth c even	5		First, Middle, Last) Ostkowski						е (ғігзі, міосіа, na Норра		9)
and Men is marks sumatic	-		me/Ralationship (19b. Mail	ing Address (Straa	end Number or Rui			State, Zip Code)
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nert of He int: If New ary or oth	208			Removal from Stata	Ce	matary, cra	osition (Nama of matory or other pla Cemetery		Aug 16,		City or Town, Stata Maryland
Departmen Important: any injury once.		. 11	naral Service Licer	plications that caused ona cause on aach li		2	2. Nama and Addra	ass of Facility	F	. 1 17	DA
Medical saminer and saminer we physician and was the bunal-transit medical Examiner	Se if a car	mediata Causa (easa or condition ulting in death) quentially list con ny, leading to im se. Entar Unde use (Disease or t initiated eventa ulting in death) L	nditions, mediata rlying injury	a	Due to (or	as a conse	MONOXIDE equenca of): equanca of): equance of):	POISONIN	G		
d by the attending physetached for use as the	Par	t II. Other signifi	icant conditions o	ontributing to death b	ut not rasu	lting in tha	undarlying causa gi	van in Part I.	23b. Did 1	lobacco use con	ntribute to the cause of
70 3				Pitt				343	10	Yes 2 No	3 Probably 4 Ur
gned by the se detached by Physic			337							an autopsy rmed?	24b. Were autopsy find available prior to completion of cau of death?
9 5 V		1							M	Yes 2□No	Was 2□N
te has been signe page 2 should be d											
his certificate has been signeral director, page 2 should be d	25.	Was casa refan axaminer? 1 Yas 2 Manner of Death	No 1 5 ☐ Pending	Hospital: 1 Inpation 28a. Date of Injunction (Mogth, Date of Injunction)	rv	ER/Outpetion 28b. Time Injury 5:55	of P 28c Inju	ry at	oma 5 🗆 Resid 28d. Dascribe I	dence 6 Other	ed INHALED EX
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ORIGINAL



		1. Decedent's Nam	e (First, Middle	, Last)		Cei	tificate of	Death	2. Date of De	Reg. No.	0 2	3. Tima of Death
Phys /Me	ician dical	Mildred I	Lavina 1	LeCates					August	7, Day 2000	Year	11:35 a.m.
Exam		4a Fecility Name (I							Location of Deat	4c. County	of Death	
F		Magnolia 5. Social Security N		ursing n		s. last birthday)	If Under 1 Year				ent 9. Birthol	lece (State or Foreign try)
Funer Directo		212-10-02	270	1□ M 2XF	95	Yrs.	Months Days	Hours Min	July 6.			ctown, MD
pun		Usual Residence of 10a. Stele	Decedent 10b. County		10c. (City, Town or Lo	cation				10	Od. Inside City Limits
Maryla of show	tor	Maryland	Kent		Ch	esterto	wn					1 ☐ Yes XXNo
or 25a-f	Directo	10e. Street and Nur	mber				10f. Zip Code			10g. Citizen of \	What Count	try?
173s		24625 Che	esterto					1620		USA		
hours after de turel', or items at Examiner, n	by Funeral	11. Marital Status 1 ☐ Never Merri 3 ☒ Widowed	-	Armed	ecedent Ever in Forces? s 2 No Give Dates:		Nas Decedent of f Yes, specify Cub	Hispenic Origin? (: ean, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify	e - America ck, White, e Whi	etc.
8.2 should be flied within 72 hours at 1) and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam	Completed			grade complete		16a. Deced (Give life.	ient's Usuel Occu kind of work done OO NOT use retire	pation during most of wo	orking	16b. Kind of B	usiness/Ind	lustry
d will glers or ther	Comp	Elementary/Seco	endary (0-12)	College	(1-4or 5+)	Teleph	one Oper	ator		Telepho	ne/Co	mmunication
d of the file	Be	17. Father's Name			174				me (First, Middle			
hould d Men marks	To	George V				10h Mailir	na Addrage (Stree	EVa Do	wney Hat			Code
27 ls 1		Joan Hato		ip (Type, Frid)			-	e Road,				
of Ham		20a. Method of Disp		o [] Down at 4 a	20b		sition (Name of netory or other ple		Date	20c. Location -		
mit. Pages partment of I portant: If Its y Injury or of			5 Other (Sp	3 □Removal fro ecify)	III State		emetery		8/9/2000	Cheste	rtown	, MD
Depart Import any in	SUC	21. Signature of Fu	ineral Service L	Dell.	2	Fe		ess of Fecility lelfenbei Road, Ch				ome, P.A.
Physicia /Medica Examine	r r	Immediate Cause (disease or condition resulting in death)		· Q	Herio.	5 Ono 7		diores	eul or -	Dise ca	e	Onset and Death
ate be executed hysician and the burial-transit	i Examiner	Sequentielly list co if any, leading to im cause. Enter Under Cause (Disease or	nditions, nmediete erlying	6.	Due to	(or as a consec	uenca of):			55		
death certificate be executed eattending physician and of or use as the burial-transition of for use as the burial-transition.	Medical	that initiated events resulting in death) i		d	Due to	(or es a conseq	uence of):					
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hat the	by Phys	Ane	mai			Ziele			10	Yee 20 No	3 Prot	bably 4 Unknown
> 17 0	Completed b	<u> </u>							24a. Wes	an autopsy ormed?	ava	ere autopsy findings allable prior to mpletion of ceuse death?
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Physician: The lav this certificate has ral director, page 2	Be	25. Was case refer exeminer?	red to medical	Messiteli				7 -	eeth (Check only	one)		
Physic this o	- To	1 Yes 25			Inpatient 2	ER/Outpetier	I 3LI DOA		Home 5 Res	how injury occur		r)
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral i	Certification:	1 Neturel 2 Accident 3 Suicide	5 Pending investigation 6 Could no	alion (Mo	onth, Dey Year)	Injury	M 1 [Yes 2 No				I Paula Mumbar
trai or Attending irs after death. af Director: After led in by the fune		4 Homicide	determin	1200. PIE	iding, etc. (Spe	nome, tarm, str	eet, factory, office			Street end Numl wn, State)	per or mure	r Houte (vumber,
To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	2 Certifying 2 Medical E	xaminer: On the	he best of my k basis of exami anner stated.	nowledge, death nation and/or in	occurred at the t vestigation, in my	ime, dete and plac opinion, death occ	ca, and due to the curred at the time,	cause(s) end medete and pieca,	enner as st end due to	teted. the cause(s)
To the within To the	Σ	29b. Signature end	title of certifier	10				se number		29d. Date signe	d (Month, I	Day, Year)
		1)	ann of	1100	100)			7036		8/8/	00	
		30. Name and addr						0.0				
	20	Juson,	V Pasa	ins	5/6/	last.	to to	0 (1)	strtown	ma	211	1201

AUG 8 2000 Parent Al. Personal

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev 7, Elizabeth Beasten Miller 2000 August 5:20 a.m. 4e Fecliity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Chestertown If Under 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Dey, Year) Kent If Under 1 Yeer 6. Sex 7. Age (In yrs. lest birthdey) Months Deys 1 M 2 XF 93 Yrs. March 13, 1907 Maryland 10c. City, Town or Location 10b. County Kent Kennedyville 10g. Citizen of What Country? 10f, Zip Code

Examiner Chestertown Nursing & Rehab. Center 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Director 213-24-2356 Usual Residence of Deceden the Meryland 10d. Inside City Limits 10a. Stete r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Directo 10e. Street and Number filed within 72 hours efter death with Hygiene. 12570 Augustine Herman Highway 21645 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White À 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11 Own home Homemaker 7 is marked other traumatic event, if permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Samuel Hill Beasten Emma Grantlin 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 5765 Langford Bay Road, Chestertown, MD 21620 of Disposition (Name of Dete 20c. Location - City or Town, State Rebecca Startt 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 1 □XBuriei 2 □ Cremation 3 □ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chester Cemetery 8/10/2000 Chestertown, MD 22. Name end Address of Feclity 21. Signature of Funeral Service Lig Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 Approximate the mode of dying, such as cerdiac or respiretory errest, that ceused the deeth. Do not enter the Intervel Between Onset and Deeth **Physician** terioschotic Cardiovascular Disec /Medical Immediate Cause (Finel Oyears disease or condition resulting In deeth) Examiner Examiner The law requires that the deeth certificate be executed physician and s the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): for use as signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. 1 Yes 2 40 3 Probably 4 Unknown p 24b. Were eutopsy findings eveilable prior to completion of cause of death? should 24e. Wes en eutopsy performed? Completed hes 76.2 s certificate he 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Was cese referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 | Inpetient 2 | ER/Outpatient 3 | DOA this After this funeral 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Director: A 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Euneral Displaying Tilled in Inc. Hospital 29e. Certifier **Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner as steted. edical

(Check only one)

29b. Signeture end title of certifier

Susan K. Ross

Physician

/Medical

State Registrar

31. Dete filed (Month, Dey, Year) AUG 8 2000

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

moters



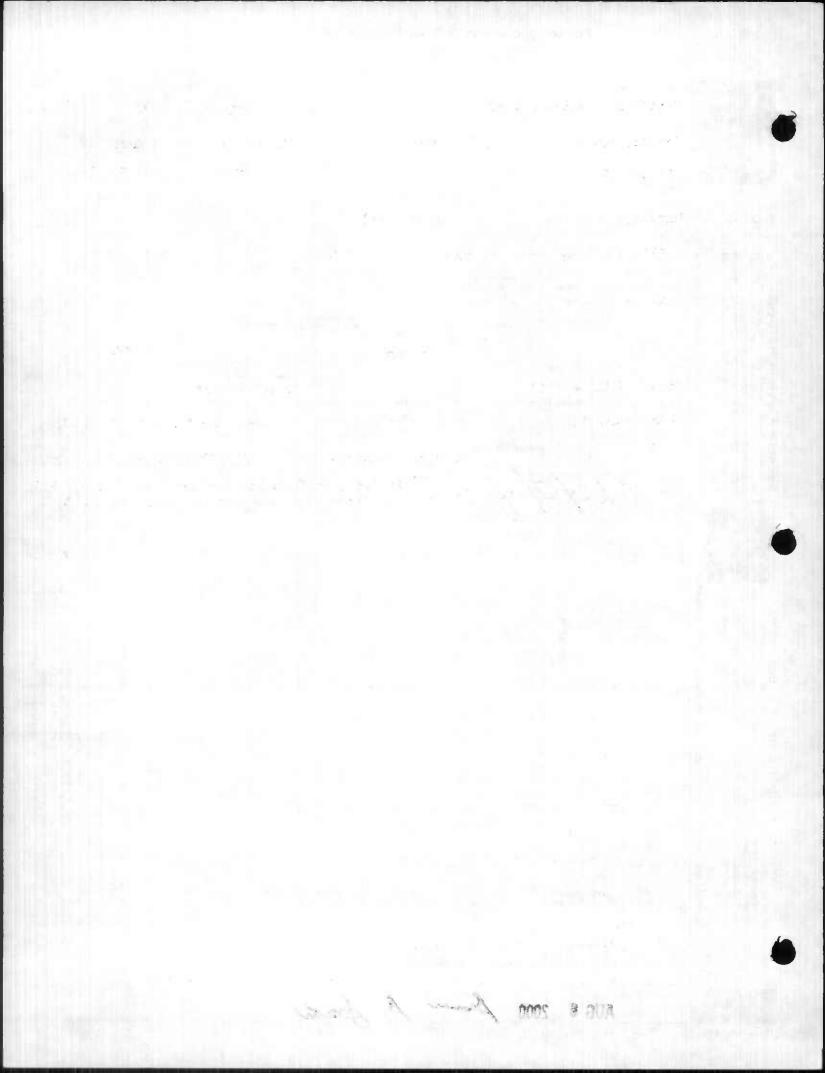
lestatown Med 2/620

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) end menner stated.

29c. License number

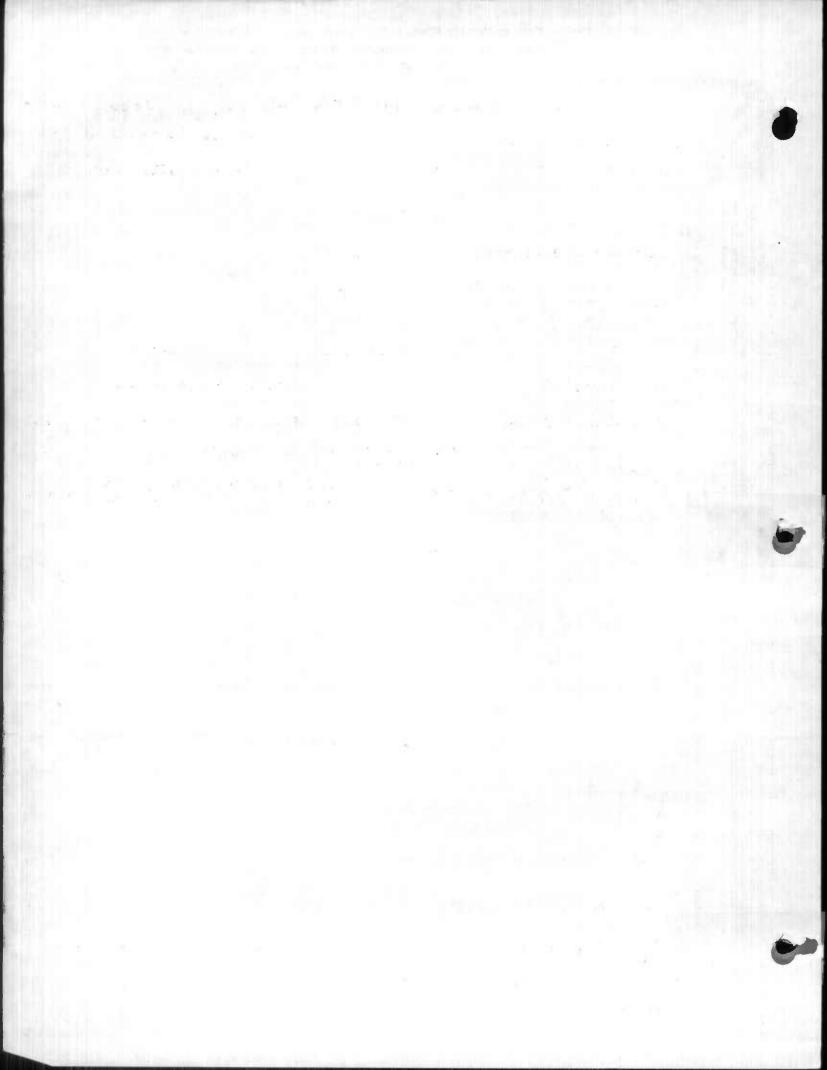
29d. Date signed (Month, Dey, Year)

within 2 To the I



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. 1.	ecedent's Name (First,	Middle, Las	t)						2. Dete of D			3. Time of Death
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dical	48	Facility Neme (If not inst					-		b. City, Town, or			inty of Death	
niner		120 UH							UMIE			2501	VO
ol lo		ociet Security Number	6. Se	×		s. iest birthdey		r 1 Year	If Under 24 Hrs	8. Date of B		9. Birth	plece (Stete or Foreigntry)
al or		14-36-931 et Residence of Decede	7	XM 2□ F	8	36 Yrs.	Months	Deys	Hours Min.	Sept.	17, 191:	3 Ma	ryland
		Stete 10b. Co	ounty		Later State	City, Town or L							10d. Inside City Limit
cto			larfo	rd	V	White	_						
Dice	10e	Street and Number						p Code			10g. Citizen		ntry?
2		3120 Whit	се На	ll Ro	ad			2116			USA		
by Funeral Director		Maritel Status 1 ☐ Never Married 2 ☐ 3 🌠 Widowed 4 🗀 Div		12. Wes Dec Armed Fo 1 Yes If Yes, Gi Year or D	2 X No ive	U,S. 13.	. Was Dece If Yes, spe 1 Yes		lispenic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No Ricen, etc.)		Race - Ameri Bleck, White ecity: Wh:	, etc.
tec		15. Dec	cedent's Edu	ucetion		16e. Dece	edent's Usu	el Occup	etion during most of wo d)	rkina	16b. Kind o	of Business/fr	ndustry
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Con		9				Da	airy	Far			Dai		
Be Completed	17.	Fether's Neme (First, Mi	liddle, Last)						18. Mother's Na	me (First, Middl	e, Meiden Sun	name)	
0		John Henr	cy Mi	ller					Mary	Rose I	Lydeng	lous	
•	198	. Informent's Neme/Rela	ationship (T	ype, Print)		19b. Mail	ling Addres	s (Street	end Number or Ri	ural Route Num	ber, City or To	wn, State, Zi	ip Code)
		Gary Mill	ler /	Son		31	120 W	hit	e Hall	Rd. Wh	nite H	all,	MD 21161
	20a	Method of Disposition			20b.	Place of Dien	nosition (Ne	me of		Dete		on - City or T	
Olike.		1 N Buriet 2 ☐ Creme 4 ☐ Donation 5 ☐ Oth			State Be	the1 Ceme	Pres	byte	rian 2	Aug. 16	Whi	to U	all, MD
	21.	Signature of Faheral Se	-		1				ss of Fecility	2000	AATIT	Le no	all, MD
		1	//	7. 7	X				artenst	ein Mo	rtuar	y, In	c.
		The the	· X4	arie	nstei	2	24	Seco	ond St.	New F	reedon	n, PA	
	23	a. Pert Friter the disee shorty or hear failure	se, or comp	tications that	caused the de-								Annrovimoto
			. List only c	one ceuse on	eech line	eth. Do not er	nter the mo	de of dyir	ng, such es cerdia	c or respiretory	arrest,		Approximate Intervel Between
		1 1	. List only c	one ceuse on	eech line	eth. Do not er	nter the mo	de of dyir	ng, such es cerdia	c or respiretory	arrest,		Intervel Between Onset end Death
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Loraine Mssick 21614 2275 Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

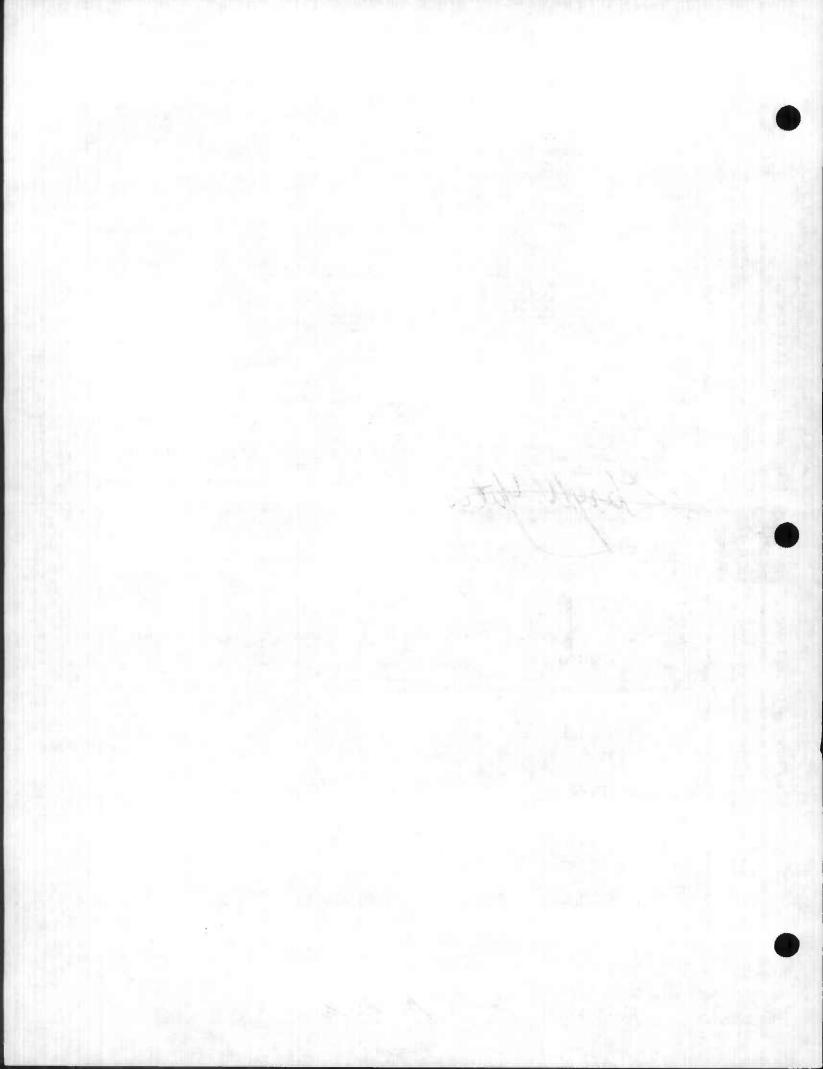
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

						Ce	ertificate	of	Death			leg. No.	L	.0 - 0 0
Physicia /Medic		Decedent's Name (First, Middle LORAIN		LLIN	IGSWOF	RTH I	MESSI	CK			2. Date of Dea	ith Dey	Yeer (000)	3. Time of Death
Examin		4a Facility Name (If not institution	AT LESS		2.3				4b. City, Tow	n, or Lo	ocation of Death	4c. County	of Death	
4		PENINSULA REC							SALI				WICO	
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs		Months	Deys	If Under 24	Min.	8. Dete of Birt (Month, De)		9. Births	place (State or Foreign
Director		216-14-2275	'X'''	201	74	Yrs.					AUG.21	,1925	MAI	RYLAND
pu *	9	Usual Residence of Decedent 10a. State 10b. County			10c. C	ity, Town or I	Location						1	Od. fnside City Limits
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/Medical Examiner	П	Immediate Cause (Piggi disease or condition resulting in death)	-	MET.	457A7	10 6	UNG		CA.	NC	ER		1	
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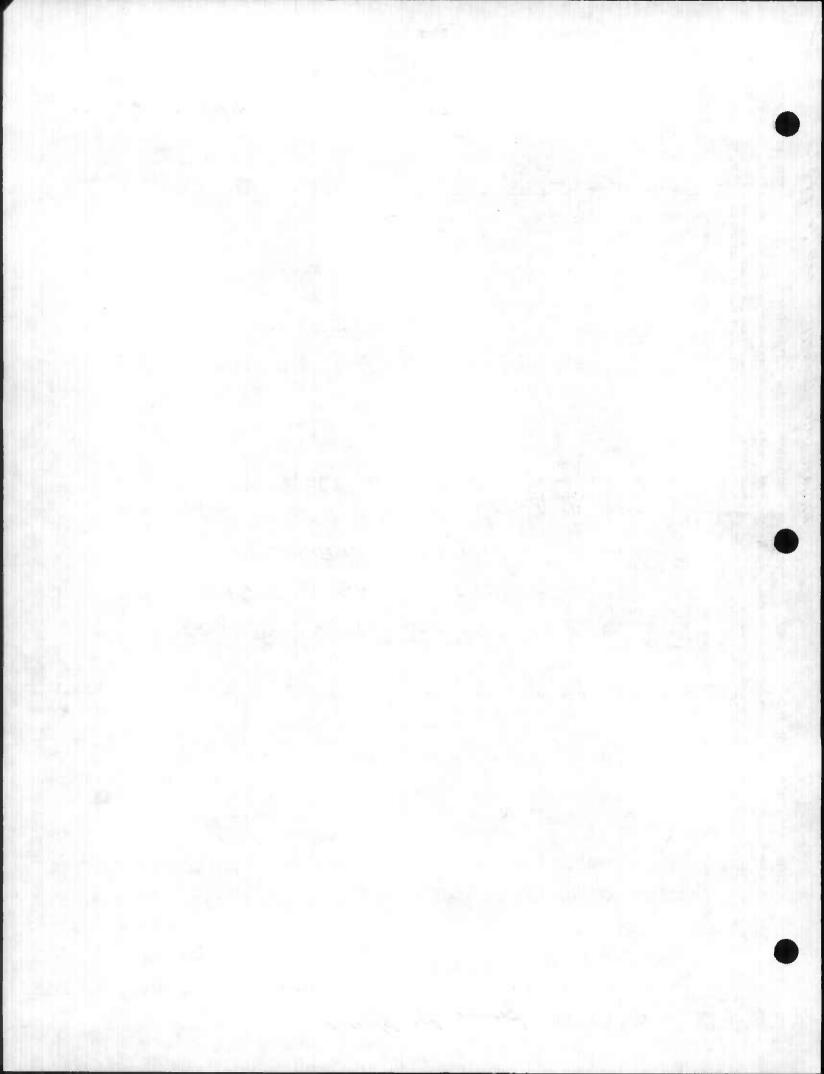
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 0 2629

	4. Decederate Manage (F)	7												
Physician	Decedent's Neme (Fi	ITST, MIGGIE, LE	ist)							2. Date of De Month	eth Dey	Y	ear	3. Time of Deal
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or 28a-1 a be notified Directo	10e. Street and Number	7	3 - 7 - 7	P. L. III		10f. Zip	o Code				10g. Citize	en of Whe	et Countr	у?
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27.1	Paula J. M	cConne	ll/Wife		606	5 Eto	n Ci	rcle,	Sal	isbury	MD :	21804	1	
The second	20e. Method of Disposit		Pamoual from S	20b. Plece cemet	of Dispos ery, cren	sition (Nemetory or	me of other plea	e)		Dete	20c. Loc	ation - Cit	ty or Tow	m, Stete
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William Mc CONNEIL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July MARGARET 28 ORTH 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** SALISBURY DEER'S CENTER WICOMICO HEAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 M 2 F Yrs. 197-26-1641 November 4,1934 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No Maryland Wicomico Director Tyaskin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3461 Tyaskin-Nanticoke Rd 21865 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd Everett Orth Jenny Landolfi 0 19e. Informent'a Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Catherine J. Bailey/Sister PO Box 105, Tyaskin, MD 21865 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory 7/30/00 Salisbury, MD 21. Signature of Funeral Service Light 22. Neme and Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 lleran 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause to each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST CARCINOMA disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 20 No 28a. Dete of Injury (Month, Day Year) 28b. Time of 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed burial-transit Box 68760, the usa as signed by the at 3 be detached to Records, P.O. page 2 certificate | Division of Vital or Attending Physician: After this funeral i Director: Aft of in by the fur filled in by

Funeral

Director

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r than "natural", or items the Medical Examiner m

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permit. Page Department of Important: If eny Injury or page.

Physician /Medical

Examiner

the

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If hem 27 is marked other than "natural", or hema 23.

21215-0020

altimore, Maryland

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of tnjury - At home, ferm, atreet, fectory, office building, etc. (Specify) 4 Homicide

To the Hospital within 24 hours a To the Funeral C

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

my cm

29c. License number 29d. Date signed (Month, Day, Year) D33905

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIRGINIA A. D. WANY M.D., CMD

ROBOY 2018 SALISBURY Md 21802

28,2000

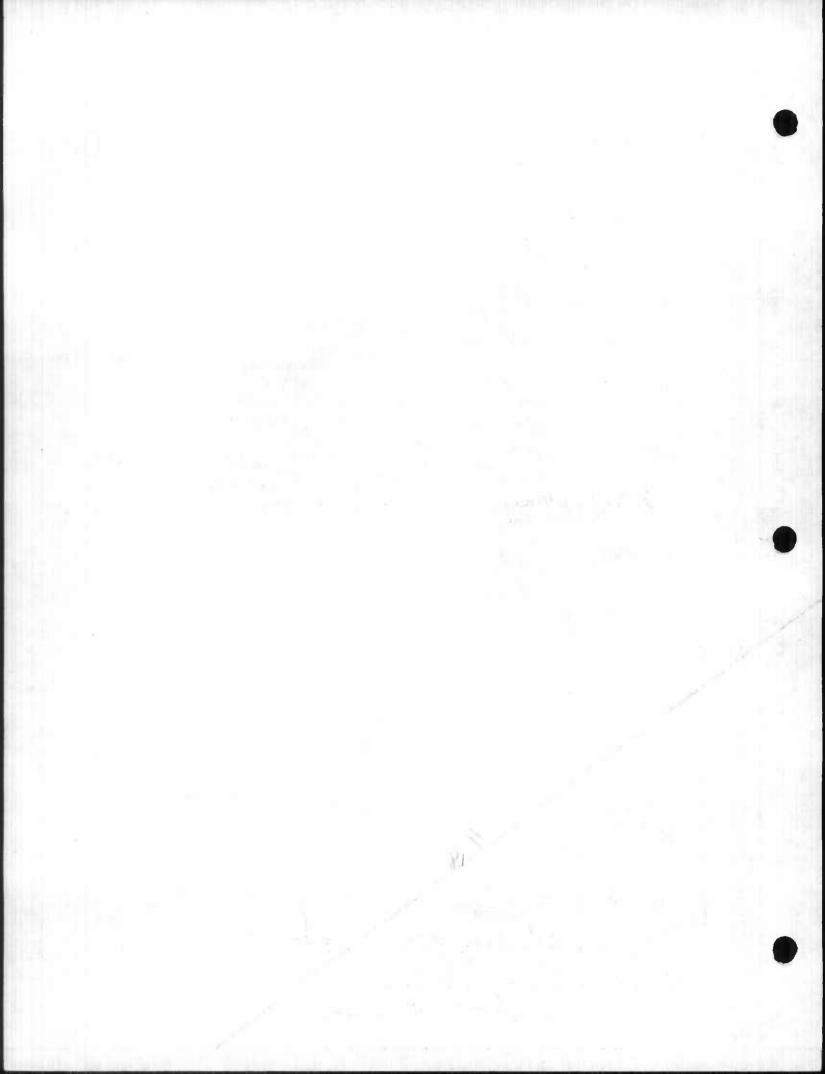
State Registrar

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29a. Certifie

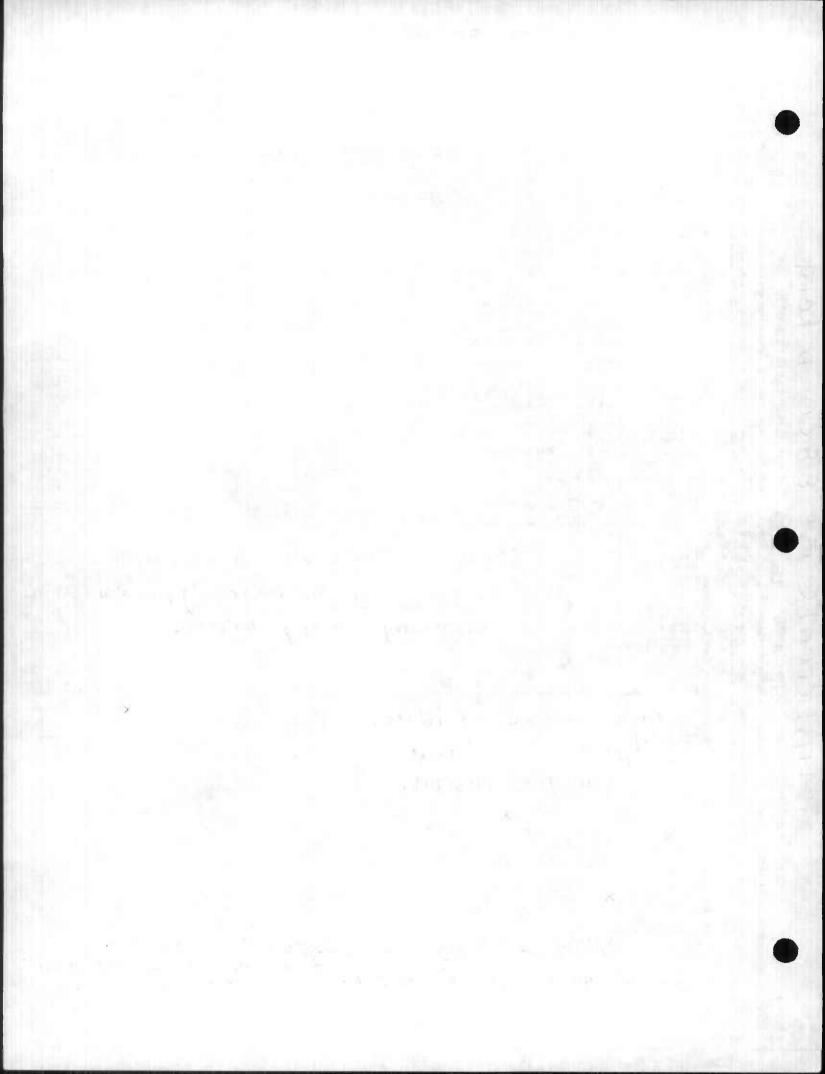
(Check only one)

31. Date filed (Month, Day, Year) 32. registrar's Signature AUG 0 2 2000



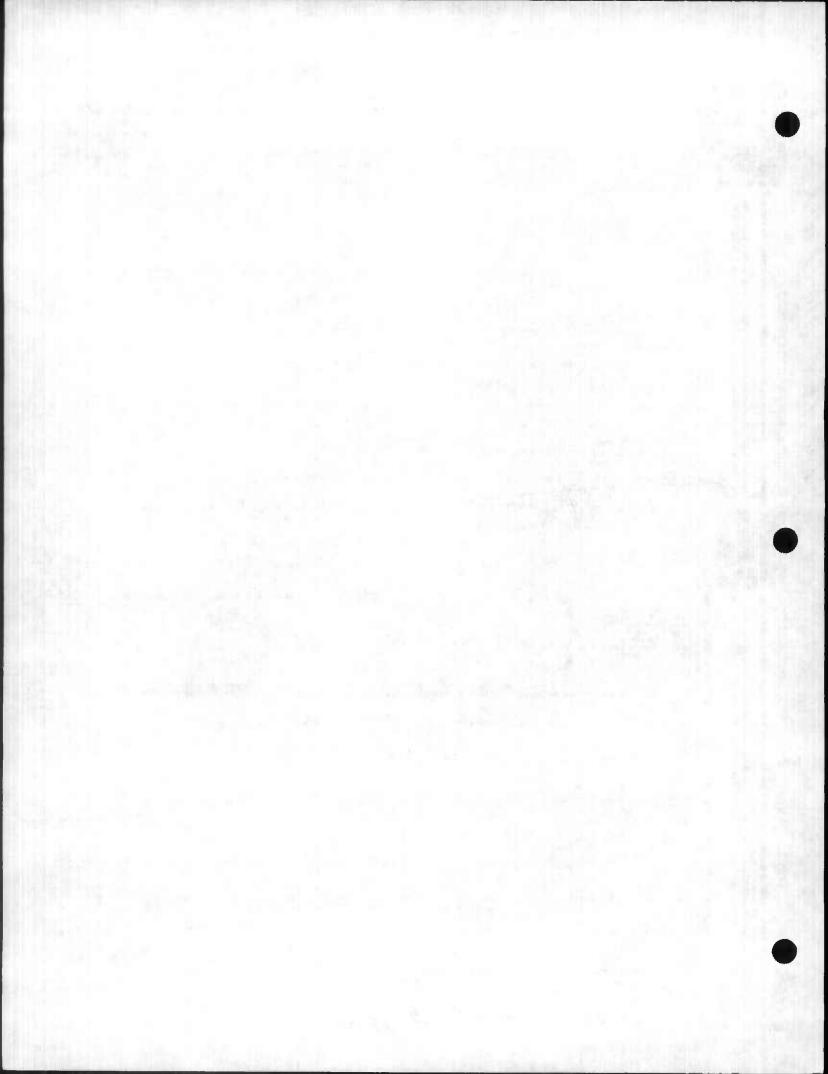
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 26299

					Certificate o	f Death	F	Reg. No.	C. 1	063.	-
		1. Decedent's Name (First, Middle,	Last)				2. Date of Des		V	3. Time of D	eath
	Physician	Richard Fost	ter Petty	Jr.			August	B, 20	Year 00	3:10	D.m.
	/ /Medical Examiner	4a Facility Name (If not institution,				4b. City, Town, or I		_		3.10	p · iii
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-	Funeral		6. Sex 7. Ag	ge (In yrs. last bi	irthday) If Under 1 Ye	ar If Under 24 Hrs.		. Vanel		ice (Steta or	
M.	Director	250-36-6816 Usual Residance of Decedant	15 M 2□ F	72	Yrs. Months Day	ys Hours Min.	10-27-	1927 \$	outh	Carc	lina
	# 8m	10e. Stata 10b. County		10c. City, Tov	n or Location				10	d. Inside City	Limits
	Man Hed	Maryland Char	rles	Bryan	ns Road					1 Yes	2 No
	or 28e-1	10e. Street and Number		1	10f. Zip Code	9		10g. Citizen of V	/hat Count	ry?	
	8 4 7	7305 Judi Driv	V 0		206	16	Τ.	Inited	Stat	99	
0	ther death r thems 23 siner must Funeral	11. Marital Status	12. Was Decedant	Evar in U.S.		of Hispanic Origin? (Suban, Mexican, Puerl			a - America	n Indian,	- 72.7
- 0	Fu din F	1 Never Married 2 Marrie	Armed Forces?				o Hican, etc.)		k, White, e	IC.	
Ko 170	Est.,	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1947	1 ☐ Yes N	No Specify:		Specify	Wh	ite	
Dr. Ko 21215-0020	ygiene, ygiene, ner than "natun t, the Medical.	15. Decedent's (Specify only highest	Education grade completed)	168	. Decedent's Usual Oc (Give kind of work do	cupation ne during most of wor	kina	16b. Kind of Bu	siness/Ind	ustry	- 18
6. 2	And and and and and and and and and and a	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use ret	ired)		Unit	ed S	tates	5
A STATE OF THE PARTY OF THE PAR	Co Co	10		Ex	olosive O					nt	
5	SEPE O	17. Father's Name (First, Middle, L.	ast)			18. Mother's Nam	ne (First, Middle,	Meiden Sumem	Θ)		
V si	Mon Man	Richard Foste				Effie	-				
)O Maryland	2 SP	19a. Informant's Name/Relationshi			b. Mailing Address (Str						1.0
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more G	Pages 1 ent of H nt: If lie ry or of	20a. Method of Disposition 1 Quital 2 Cramation 4 Donation 5 Other (Spe	3 □Removal from State	in ity I	of Disposition (Name of ary, cremetory or other) Memorial	Gardens	t 11, 2	20c. Location - 2000 Valdorf			nd
@ #	military and a second	21. Signature of Funeral Service Li		1	22. Name and Ad	dress of Facility					
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0		23a. Part1. Enter the disease, or conshock, or heart failure. List o	complications that cause	the death. Do	not enter the mode of	wthorne dying, such as cardiac	or respiratory ar	rest,		Approximate	
100	Physician	snock, or near tallure. List o	nly one cause on each i	ine.						Interval Betw Onset and De	eath
430	/Medical	Immediate Cause (Final disaase or condition	4	rute	Cma	0 02'110	hossi	+ 60%	IXP		
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00	ian a urial.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events		- norm	Dary F	trtem!	Disea	MP			
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4 4	The page	Diale	etes m	lellitu	\$		101	res 2 No	1	Yes 201	No
Petty Vital Reco	lan: ntifica ctor,	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o	ne)			
	Physician: this certific ral director, TO Be (1 Yes 2√2 No	Hospital: 1 Inpati	ent 2 ER/O	utpatient 3 DOA	Other: 4 Nursing F	lome 5 🗆 Resid	denca 6 □Oth	er (Specify)	
n of	ding Ph h. After th funeral	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju			njury at Work?	28d. Dascribe h	now Injury occur	red		
<u>ō</u>	death. ctor: Af y the fu	2 ☐ Accidant invastigs	ition			Yes 2□No					
Division	er de er de by ti by ti	3 Suicide 6 Could no determin	and 286. Placa of in	jury - At home, f	arm, street, factory, offi	се	28f. Location (S City or Tox	Street and Numb	er or Rura	Routa Numb	oer,
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	To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral dire Medical Certification: To	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best xaminer: On the basis of and manner st	of examination a	e, death occurred at the nd/or investigation, in m	a time, dete and place by opinion, death occu	, and due to the erred at the time,	cause(s) and me date and place,	enner as st and due to	ated. the cause(s)	
	of the omple	29b. Signature and title of certifier	with the mind of		29c. Llc	ense number		29d. Date signe	d (Month, I	Day, Year)	
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		20 Name and adding	ho completed course of	doub (hor on)	(Type Bright)	9135	2.1000	to bear	R	# -	210
		30. Name and address of person w	AD F.	KOLI	A. M.D.	(1)	NEDAL	mon	207	3 C	170
	State	31. Date filed (Month, Dey, Year)	32. Regist	ray's Signature	1.	1	1010,	1-10	x 0 / .		
1.41.	Registrar		0 2000	Deperson	D. A.	parker					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 263 []

	Certificate of Death	F	Reg. No.	20000
4	Decedent's Nama (First, Middla, Last)	2. Data of Dea Month	ith Day Ya	3. Tima of Death
Physician /Medical	ROBERT THOMAS RUSSELL	July	30 20	11/6
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc			
	PENINSULA REGIONAL MEDICAL CENTER SALISBUR	Y	WIC	OMICO
Funeral Director	5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day July 2	, Year) 19,1923	Birthplaca (State or Foreig Country) Maryland
P	Usual Rasidence of Decedant			
nylar	10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limit
the Maryle 28a-f sho notified a	Maryland Wicomico Salisbury			1 Yas 2□N
uter death with the Manylar r thams 23s or 28s-f show refer must be notified as Funeral Director	10e. Street and Number 401 Liberty St 21804		10g. Citizan of What USA	Country?
by by	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedant Evar in U,S. Armed Forcas? 1 No. If Yas, Giva Yaar or Datas: WW II	cify Yas or No- lican, atc.)	Specify:	American Indian, White, atc.
wild be filed within 72 hours Mental Hygiena. Irked other than "natural", titc event, the Medical Ex-	15 Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Busine	ass/Industry
nin 7.	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	9		
is 1 and 2 should be filed within 19 Health and Mental Hygiena. Item 27 is marked other than other traumetic event, the TO Be Comp	12 Salesman		Shoe	
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id be enta	Robert Lance Russell Anna	Lan	kford	
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d 2 should be file th and Mental Hy ?? Is marked other traumatic event To Be (Karen Sue Russell/Wife 401 Liberty St., Salis			
1 and Health em 27	20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place)	Data	20c. Location - City	or Town, Stata
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it. Page inment of chant: If	4 Donation 5 Other (Specify) Salisbury Crematory 21 Signature Cunaral Service Licensee 22 (1957) 22. Nama and Addrass of Facility	/31/00	Salisbu	ובא, ויום
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aw requir	Cardiae arrhy/kmia	24a. Was perfo	an autopsy 2 med?	4b. Wara autopsy finding available prior to complation of cause of daath?
yalcien: The la s certificate he director, page		101	ras 2XI No	1 □ Yas 2 No
certificate rector, pag	25. Was casa rafarred to medical 26. Placa of Death	(Chack only o	na)	
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After this funeral di	27. Mannar of Death 28a. Data of Injury 28b. Tima of 28c. Injury at 2		now injury occurred	
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or Atte after de Directo in by th	3 Sulcida 6 Could not be detarmined 28a. Placa of Injury · At homa, farm, streat, factory, office building, atc. (Specify)	28f. Location (S City or Tox	Street and Number own, Stata)	or Rural Routa Number,
To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	29a. Cartifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the time, date end place, a complete of axemination and/or invastigation, in my opinion, death occurred at the complete of axemination and/or invastigation, in my opinion, death occurred at the complete of axemination and/or invastigation, in my opinion, death occurred at the complete of axemination and/or invastigation and occurred at the complete of axemination at the complete of	and dua to that ad at tha tima,	causa(s) and manne data and place, end	er as stated. due to the cause(s)
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1340	30. Nama and addrass of parson who complated cause of death (Item 23a) (Type, Print) BENITO S. CHAN 5476 River sede	2.	Salske	MD 2/8
State Registrar	31. Data filed (Month, Day, Year) 32. Registrar's Signatura ALIG 0 2 2000			/



State of Maryland / Department of Health and Mental Hygiene 00 2630

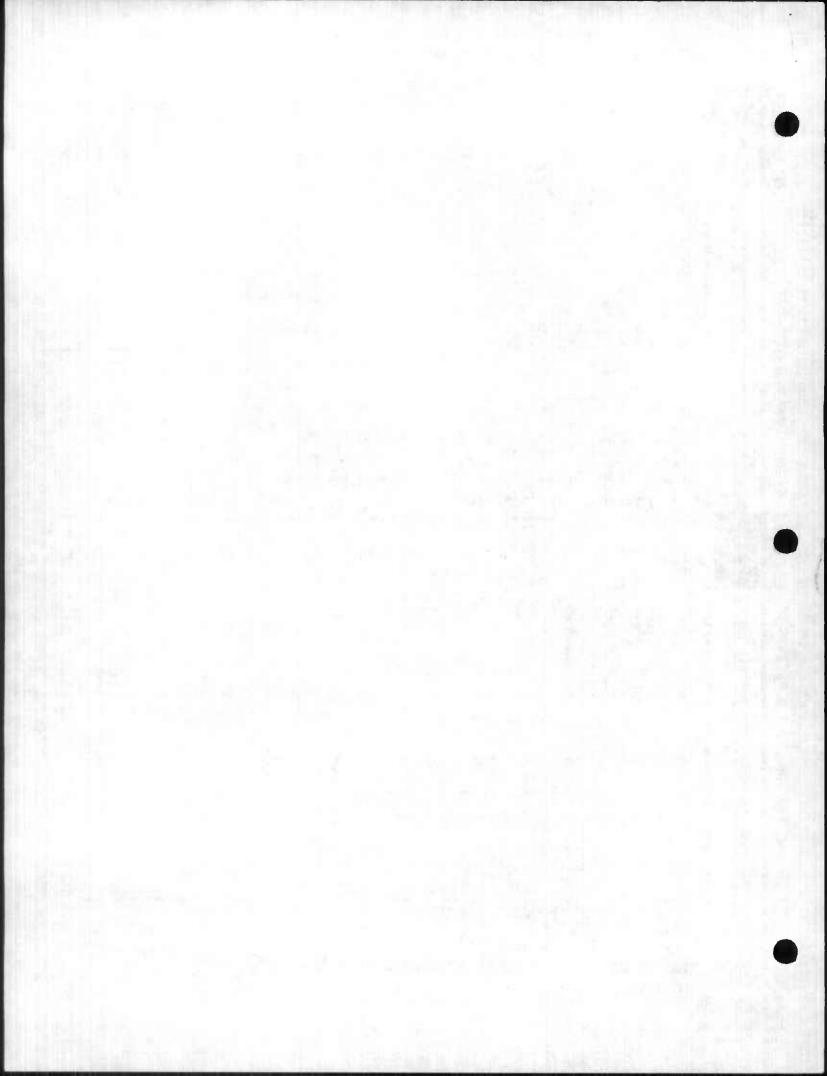
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		Physician /Medical	Lillian Virginia Smith	August	4, 2000	06:34a
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		pu	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
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LUAN		death with the Maryland ima 23a or 28a-f ahow inners be notified at nersi Director	10e. Street and Number 7050 Old Washington Road 21797		0g. Citizen of What C	A.
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F	5-0	neturel:	15. Decedent's Educetion (Specify only highest grade completed) (Giva kind of work done during most of life. Do NOT use retired)	f working	16b. Kind of Business	
-	121	5 6 0	Elementery/Secondery (0-12) College (1-4or 5+)		Clothin	g Industry Industry
HLIWS	12	be filed within 72 hot tel Hygiene. I other than "neture event, the Medical Be Completed	6 Inspector	None (First Middle A		Industry
V)	Maryland 21215-0020	should be fit and Mentel H marked out umatic ever	17. Fathar's Name (First, Middle, Last) William Lucas Em	Neme (First, Middle, M Ma Childs	raiden Surname)	
		nd 2 shall all and 27 is m	19e. Informent's Name/Reletionship (<i>Type, Print</i>) Mrs. Mary Rash (Daughter) 19b. Mailing Address (Street end Number 7050 Old Washington			
	Baltimore,	80= 8	20e. Method of Disposition 20e. Method of Disposition 20e. Plece of Disposition (Name of cemetary, cremetory or other plece) 20e. Plece of Disposition (Name of cemetary, cremetory or other plece) 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify)		20c. Location - City or Glen Burn	
	Balti	permit. Pa Department Important: any injury once.	21. Signeture of Funeral Service Licensee 22. Name and Addrass of Facility HAIGHT FUNERAL			
	г		Sykesville, MD 23a. Part 1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as called shock, or heart feilure. List only one cause on each line.	21/84 (41 ordiac or raspiretory error	0) - 795 - 140	Approximeta
	0	Physician /Medical Examiner	Immediate Cause (Final disease or condition rasulting in death) a. Right middle Wise			Interval Between Onsat and Daath
		61	Due to (or es a consequence of):			
		nsit min	Desorentia			
	Box 68760,	The law requires that the death certificate be assocuted at these been signed by the attending physician end page 2 should be deteched for use as the burial-trensit completed by Physician/Medical Examines.	Sequentially list conditions, if any, leading to immadiale cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of):			
	m .	death ce e attendii d for use	Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did to	bacco usa contribu	te to the cause of death'
	P.0	ed by the deteched	CVA, HIDDO	1 🗆 Y	2 No 3 1	Probably 4 Unknow
	Division of Vitai Records, P.O.	The law requires thet the death certificate has been signed by the attending page 2 should be deteched for use a Completed by Physician/M.		24e. Was a perforr		. Were autopsy findings available prior to completion of cause of death?
	R	The lay		1 □ Ye	as 2 No	t Yes 2 No
	ita	ysicien: The last certificate he director, page	25. Wes case referred to medical axaminer?	of Death (Check only on	16)	
	>	Physician: this certificant all director, TO Be (1 Yes 20 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nurs	ing Home 5 🗆 Reside	ence 6 Other (Sp	ecify)
	ion o	After fune	27. Menner of Death 1 Neturet 5 Pending (Month, Dey Year) 2 Accident investigation 28a. Dete of Injury 28b. Time of Injury 4 North, Dey Year) 4 North, Dey Year) 4 North, Dey Year) 4 North, Dey Year) 4 North, Dey Year)		ow injury occurred	
	Divis	after deeth Director: A d in by the f	3 ☐ Suicide 4 ☐ HomIcide 6 ☐ Could not be determined 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
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		To the company of the	29b. Signeture and title of certifier 29c. License number D 5[7]		9d. Date signed (Mor	
			30. Nema and address of person who completed ceuse of death (Item 23a) (Type, Plint)	asta i	4. 2-	0 1110-
			m. PANSURIYA 4197 Makolm DR, No	estmins	10 m	021157

State Registrar

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32. Registrar's Signeture

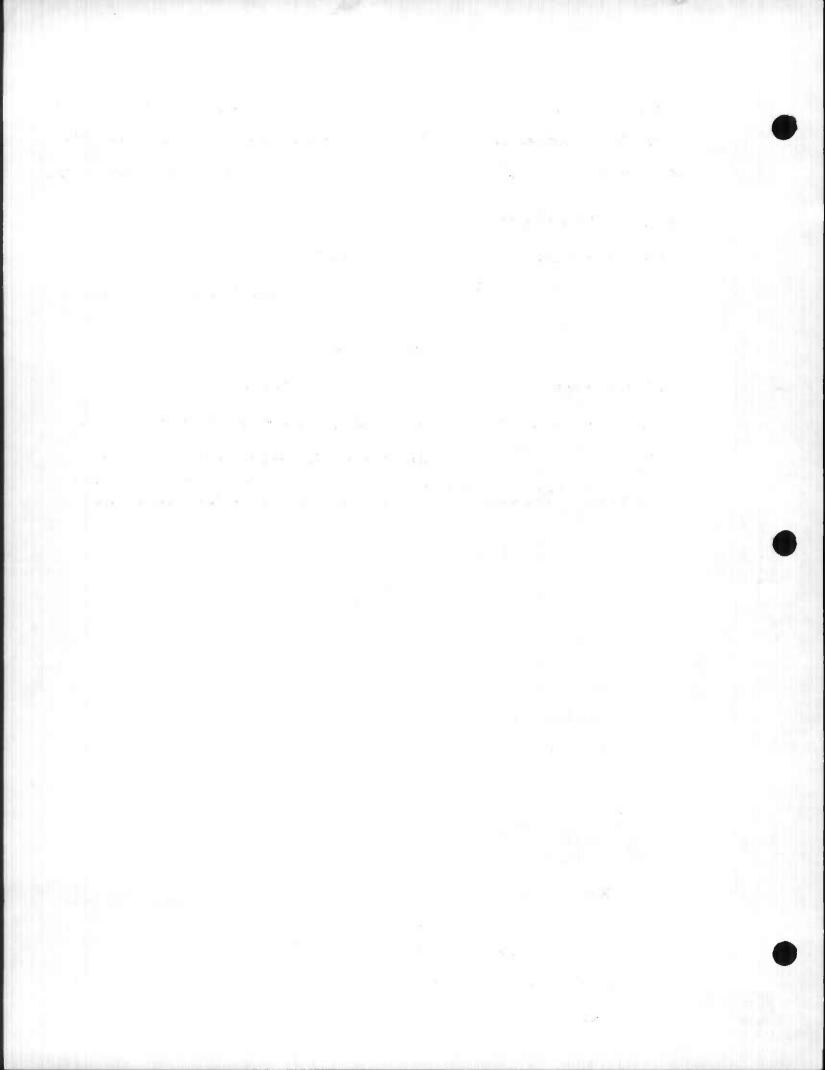


State of Maryland / Department of Health and Mental Hygiene (

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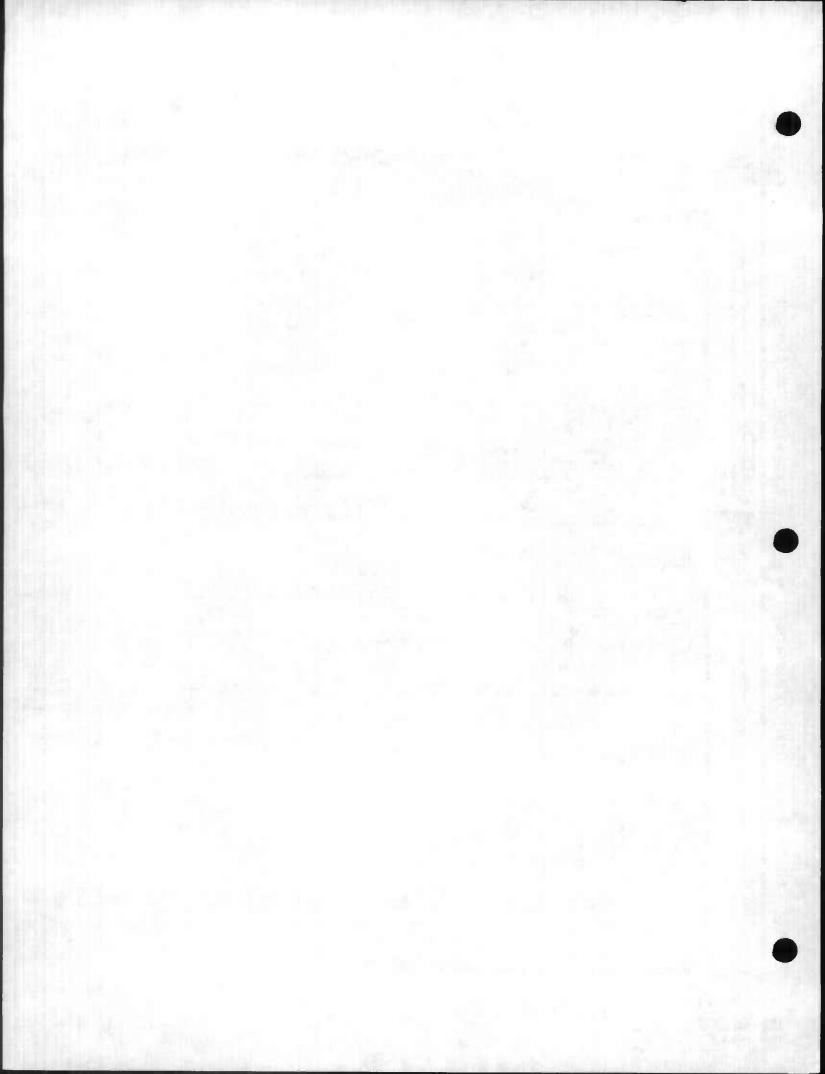
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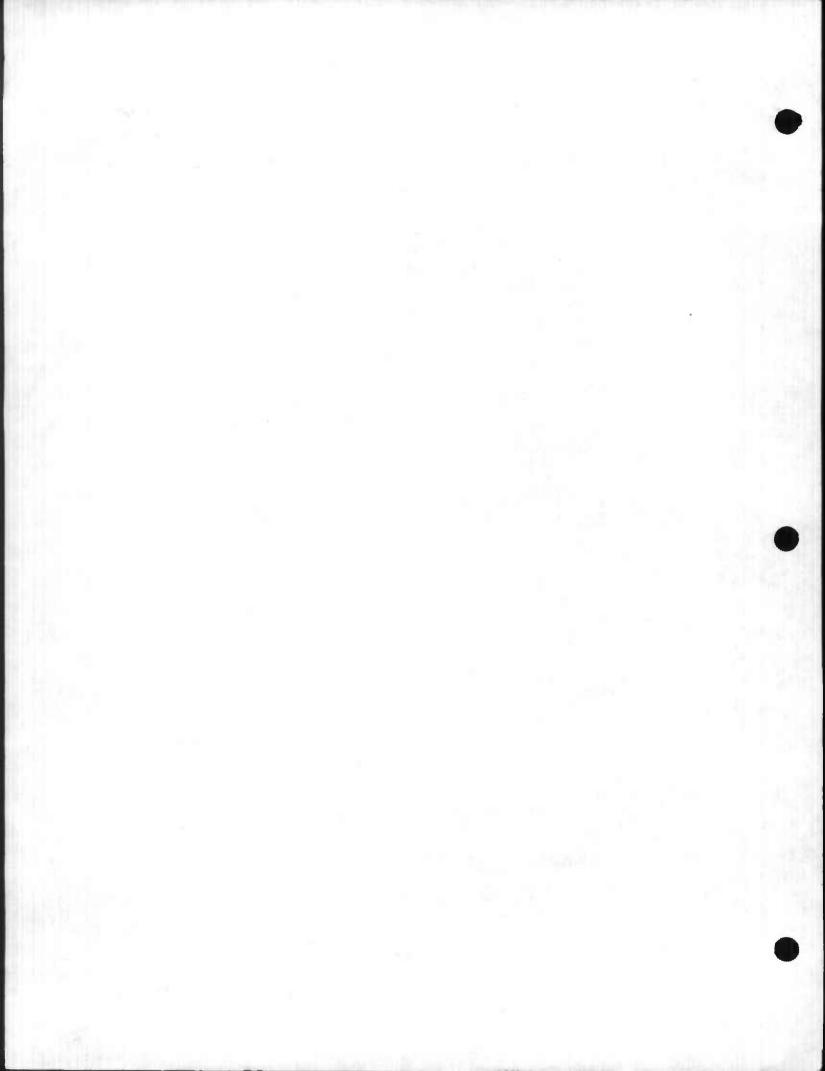
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JOAN MARIE SMITH 2000 12:15PM August /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner H Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Days Hours Min. 0600 Pec. 2, 1927 2762 Pinewood Drive Charles 9. Birthplace (Stele or Foreign Country)
West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F 72 Yrs. 232-38-0418 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Maryland Charles Waldorf Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be r 2762 Pinewood Drive 20601 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Government filed within Elementery/Secondary (0-12) College (1-4or 5+) File Clerk Supervisor F.B.I. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be nent of Health and Mental inti If Item 27 is marked o 7 is marked of traumatic evi Ethan A. Cooper Maggie Ethel Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cecil R. Smith, Sr./Husband 2762 Pinewood Drive, Waldorf, Maryland 20601 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Mpermit. Pages Obspartment of Amportant: if to any Injury or o 1 X Burial 2 Cremation 3 Removal from State Trinity Memorial Gardens 08-12-2000 Waldorf, Maryland 4 Donetion 5 Other (Specify) 22. Name and Address of Facility
The Huntt Funeral Home, Inc. 21. Signature of Funeral Service Licensee JOHN P. KNISLE'S M01164 P.O. Box 156, Waldorf, Maryland 20604 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final Non Hodgkins Lymphoma disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examine The law requires that the death certificate be executed burial-tren Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the Due to (or es e consequenca of): 80 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by should be detec 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? page 2 1 ☐ Yes 2 ☐ No 1 Yes 2ENO or Attending Physician: Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes XXNo this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1XX etural 5 Pending after deeth. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 2 filled in within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) end menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number D28352 August 8, 2000 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646 31. Date tiled (Month, Day, Year) 2000 Signature State 1 0 Registrar



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Month July 2000 2215 Shirley Sprankle 24 /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rt. 290 & 300 Sudlersville Queen Anne If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year) 5 Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 □ M 2 및 F 210-28-3400 Yrs. Director Sept 23, 1936 Penna. Usual Residence of Decadant the Meryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Blair 1 ☐ Yes 2 ☑ No Director Tyrone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RD 4 Box 202 16686 death USA 12. Was Decedant Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Maritai Status Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filled within 72 hours effer of tent of Heelth and Mentel Hygiene. nt: If Item 27 is marked other than "naturel", or Item 1 Never Married 25 Married 1 Yas 2 No If Yes, Give Yaar or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) own home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Clair O'Shell Flora Gummo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Dean- Daughter other RD5, Box 34, Tyrone, Pa. 16686 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State Data 8 1 Burial 2 □ Cramation 3 □ Removal from Stata permit. Pege Department of Important: If any Injury or 7-28-00 Blair Co., Penna. 4 ☐ Donation 5 ☐ Other (Specify) Eastlawn Cemetery 21. Signature of Funeral Servica Licer 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. plimitions that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, one cause on each line. 130 Speer Road, Chestertown, MD 21620 23a. Part1. Enter the diselle shock, or heart failure. Approximate Interval Batween Onset and Death **Physician** /Medicai Immediate Cause (Final IMMI=DIATE disaase or condition resulting in deeth) Examiner Dua to (or as a consequenca of) Examiner physician end the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician 2 Physician/Medical Due to (or as a consequence of): 98 ding 980 etter for ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Records, p should t 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 certificate 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) examiner? 1 X Yes 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of P 28c. Injury at Work? 28d. Describe how injury occurred Attanding After 5 Pending investigation Injury 1 Natural 1 Yes 2 No death. 7-24.00 11-,240 To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, offica quilding refc. (Specify) Location (Straet and Number or Rural Route Num City or Town, Stete) 4 \ Homicide 14290+300 (_ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certille Medical (Check anty 29b. Slonature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 30. Nama and address of person who completed cause of death (Nem 231) (Type, Print) Ralph E. Libby, M.D., 204 Medical Center Road, Grasonville, MD 21638 31. Data filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 Registrar

State of Maryland / Department of Health and Mental Hygiene

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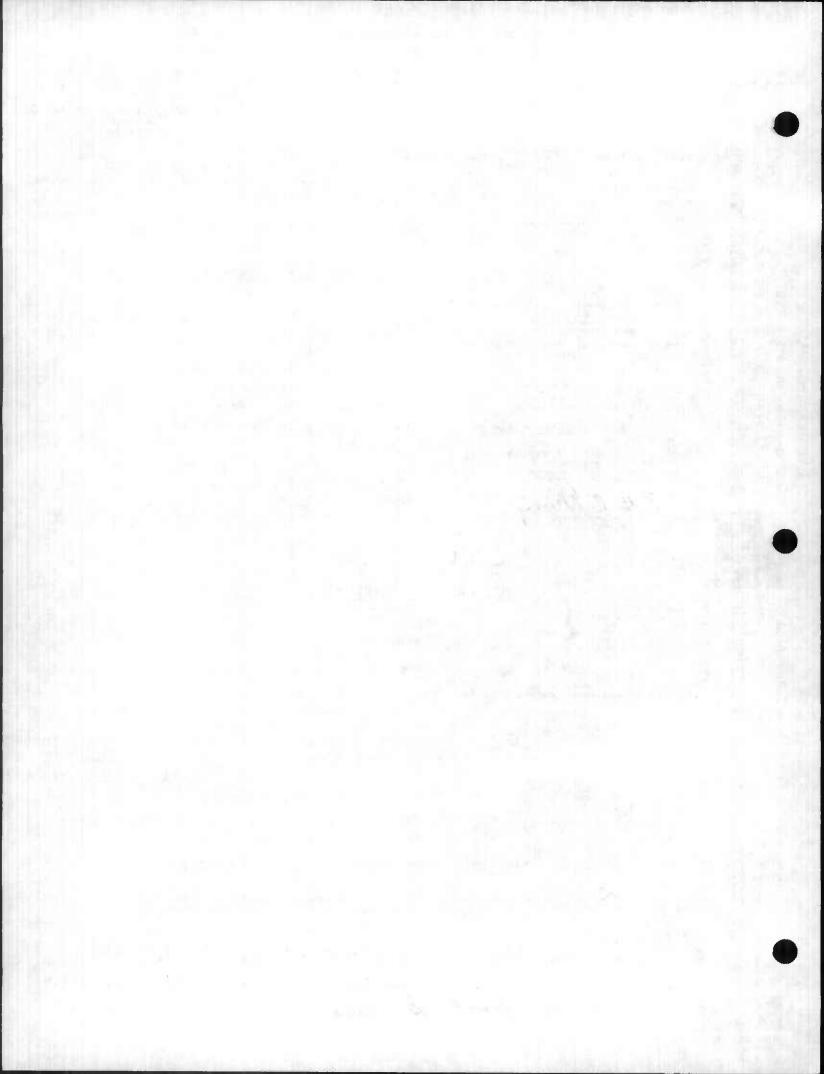
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State of Maryland / Department of Health and Mental Hygiene 00 26307

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Physician	CHARLES	WILLIAM		STEWA	RT			Tuch	00	3000	225
/Medical Examiner	4a Facility Neme (If not institution, giv PENINSULA REGION	e street and number)	CENTER				m, or Loc	ation of Death Y	4c. County		
uneral irector	5. Social Security Number 6. S 217–24–3705		(In yrs. last birth	day) If Und Month	er 1 Yaer S Deys	If Under a	Min.	B. Date of Birth (Month, De) June 4	1930	9. Birthp Cour Mar	laca (State or For
	Usuel Residence of Decedent										
notified at	10a. Stata 10b. County		10c. City, Town	or Location						1	0d. Inside City Lir
rector	Maryland Wico	mico	Sali	sbury							1 ☐ Yes 2 🔀
	10e. Street and Number 606 Douglas Roa	d		10f. 2	ip Code 218	01			10g. Citizen ot V USA	What Cour	ntry?
funeral	11. Marital Status	12. Was Dacedent E	ver in U,S.	13. Wes Dec	edent of h	lispanic Orig	gin? (Spec	cify Yes or No-			an Indian,
by	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 XYes 2 ☐ N If Yes, Giva Yaar or Detes:	orea		2⊈No	en, Mexican Specify:	, rueno n	ican, etc.)	Specify	ck, White, /: Wh	nite
a pet	15. Decedent's Ed (Specify only highest gre	ducation	16a. C	Decedent's Us	ual Occup	ation	of workin	0	16b. Kind of Bu	usiness/în	dustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Give kind of v life. DO NOT		d)	or working		D 1		
ပိ	12	1	F	Realtor		10 Motho	r'e Nama	/First Middle	Real Maiden Sumen		се
Be	17. Fathar'a Name (First, Middle, Last,					100					
To		tewart					ther		(unkr		0.11
	19a. Intermant's Neme/Relationship (196.						r, City or Town,		Code)
	Patricia F. Stew	art/wile	20b. Place of I		907	s Ra.,	Sal	Dete Dete	, MD 218		was State
nux or or	20e. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specif		cematery	bury C	r othar pla	,	7	/30/00	Salisb		
any in	21. Signatura of Funeral Service Licer	1500			_				fession ury, MD		sociatio
	23a. Pert1. Enter tha disaase, or com shock, or haart tailura. List only	plications that caused	tha daath. Do no							2100	Approximate Interval Between
ing physician and a se the bunst-transit Medical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inflated events resulting in death) Last	с.	Que to (or as a co			m					
elected for us Physician/		**									
ysic	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying	cause gi	ven in Part I		23b. Did (obacco use co	1	g,the cause of de
y Ph								10	Yes 2□ No	30 Pro	bebly 4□Unk
page 2 should be d				Pl				24a, Was perfo	an autopsy med?	201	ere autopey finds vallable prior to impletion of cause death?
Somp	DESCRIPTION OF THE PARTY OF THE							101	es alle	1	Yes 20 No
0	25. Was case referred to Medical					26 Pince	of Death	(Check only o	CE SUSTAINE		2.00
director.	examiner?	Hospital: ↑□ Inpatier	nt 2 KERVOUR	patient 3CI	004 00	har		The same of the sa	dence 6 🗆 Ott	our (Souri	M
- P	27. Manger of Death	28a. Date of Injur (Month, Day	28b Ti	Control of the Contro	28c. Inju			MODELLA CONTRACTOR	now injury occur	-	,,
	LA Natural 5 Dending	LANGE TO SERVICE TO SE	COMPLETE STATE	M		Yes 2	No				
	1-SNatural 5 Pending investigation		COLORADA DADORA MARIA	m mineral facel	ory, office		3	8f. Location (2 City or Tox	Street and Number, State)	ber or Rur	al Route Number,
	The second section and the	Office Phase of Injur	ry - At home, fan (Specify)	n, street, lact							
Funeral Director: After it tely illied in by the funeral ilical Certification:	2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined	e 28e. Place of Inju	(Specify) I my knowledge, examination and	death occurre							
leay Illed in by the tuneral loal Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Certifying Phenomena (Check only 2 Medical Example)	28e. Place of Inju- building, etc systems: To the best of niner: On the basis of	(Specify) I my knowledge, examination and	death occurre for investigati	on, in my			d at the time,		and due t	o the cause(s)
tely lilled in by the funeral lical Certification:	2 Accident 3 Suicide 4 Homicide 29s. Certifier (Check only one)	28e. Place of Inju- building, etc systems: To the best of niner: On the basis of	(Specify) I my knowledge, examination and led.	death occurre for investigati	on, in my o	opinion, dea se number	th occurre	d at the time,	date and place, 29d. Date signs	and due t	o the cause(s) Day, Year)
and Director: After It filled in by the tuners at Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Hornicide 29s. Certifier Certifying Philosophy (Check pelly one) 29s. Signature and her of certifier	28e. Place of Injubiliding, etc. systician: To the best of and manner sta	(Specify) I my knowledge, examination and led.	death occurre for investigati	on, in my o	opinion, dea se number	th occurre	d at the time,	date and place, 29d. Date signs	and due t	o the cause(s)



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Day Month **Physician** Joseph Edward Skipper, Jr. 1120 Juli 26 2000 /Medical 4b. City, Town, or Localion of Death 4e Facility Nama (If not institution, give street and number) 4c. County of Death WICOMICO Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Yaar | If Under 24 Hrs. Birthplaca (Stata or Foreign Country)
 USA 8. Data of Birth 09714/1 932 7. Age (In yrs. last birthday) **Funeral** Days Hours 15 M 2□ F 67 Yrs. Director Usual Residence of Decedant 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits DE Sussex Laurel 1 Yes 2 No Directo Or Harrie 23s or 28s-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19956 USA 107 Tracey Circle Funeral 12. Wes Decedent Ever in U.S. Amed Forces? 1&I Yas 2 | No If Yas, Give Yaar or Datas:1948-1952 14. Rece - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Meritel Status 1 Nevar Married 25 Merried Specify: White 1 Yas 2 No À 3 Widowed 4 Divorced Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Fuel Handler 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Mental Alice Hyson Skipper Joseph Edward Skipper 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) . Laurel, DE artment of Health present: If item 27 19956 Dolores Skipper/Wife 107 Tracey Circle 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 7-28-2000 Millsboro, DE Delaware Veterans CEm. 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Short Funeral Home Lineage 700 West Street Laurel, DE cisease, a completations that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, tillure. List only one cause on each line. Approximata Interval Batween Onset and Deeth Physician Immediele Cause (Finel disaesa or condition resulting in deeth) /Medical PESTIPATORY FRICURD Examiner Dua to (or es a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or injury thet initiated evants rasulting in death) Last Dua to (or as a consequance of): Due to (or es a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Onknown DIABETES þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Wes case refarred to medical axaminar? 26. Placa of Death (Check only one) Hospitat: 1 Impatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 1 Yas 2 No all a 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Invastigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be determined 28e. Plece of Injury · At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide To the Hospital . within 24 hours a . To the Funeral D. 1 Certifying Phyaician: To the best of my knowledge, deeth occurred et tha tima, date and place, and dua to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Cartifiar 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signetura end titla of certifiar IV D29168 7/26/00 M.S all 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) SALISBULY, MO 540 RIVERSINE AILEN

DHMH 16 Rav 6/95

Registrar

Maryland 21215-0020

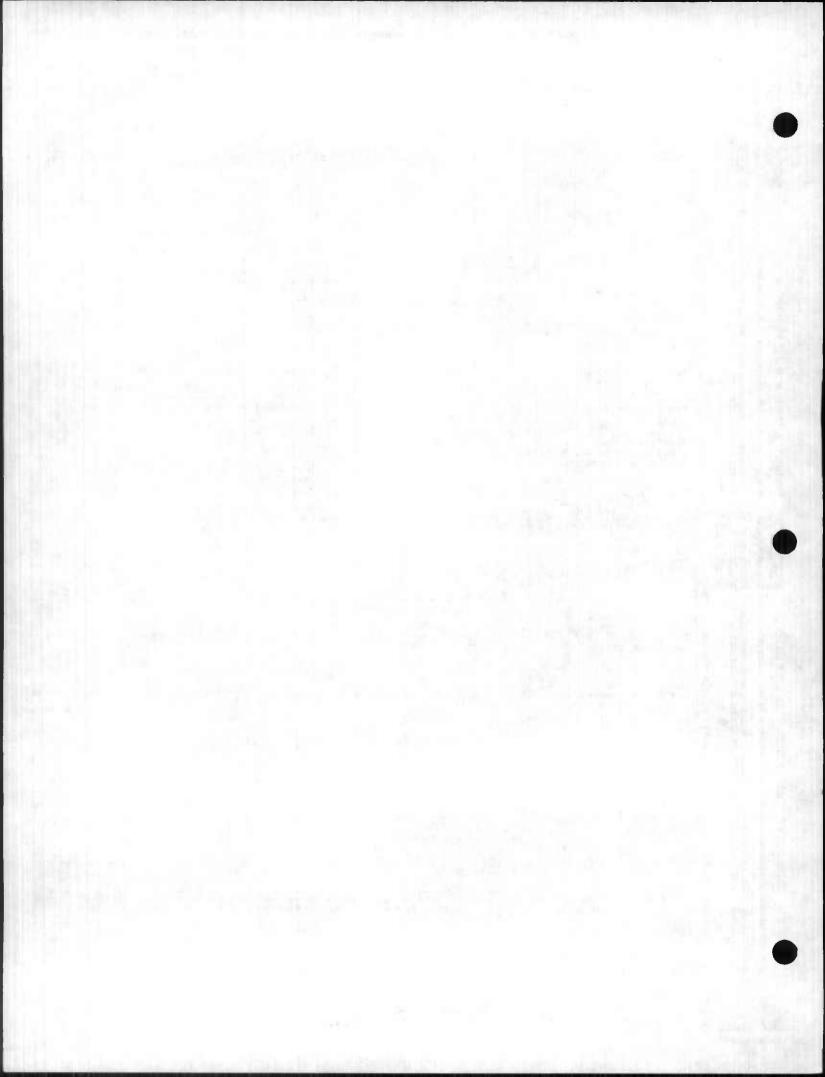
Baltimore,

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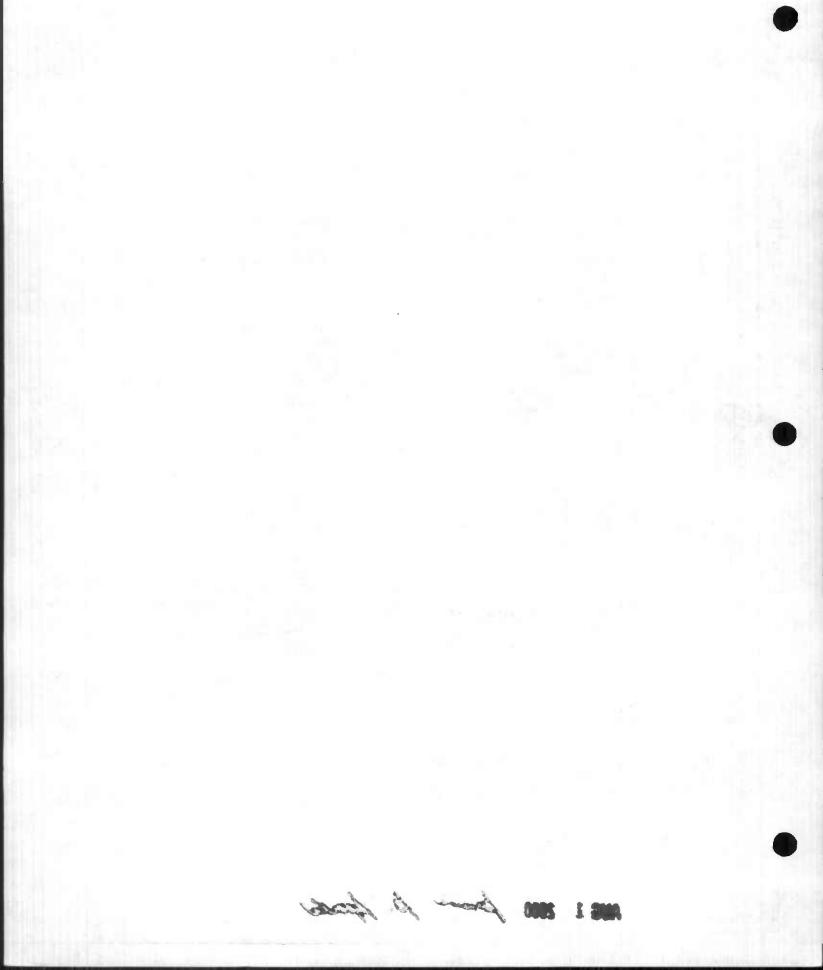
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State of Maryland / Department of Health and Mental Hygiene

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d Address of Facility	C 37	_	1
LAAR	ACCI DE	ENI	24 h
ause given in Pert I.	23b. Did tob	acco use contri	ibute to the cause of
SCULAR	1 Yes	2) (No 3	Probably 4 Ur
CIDENT	\$ 24- 111-	autono	24b. Wera autopsy find
			available prior to completion of cau
			of death?
	1 Tes	2000	1 ☐ Yes a N
26. Place of I	Death (Check only one)	
OA Other: 4 Nursing	Home 5 Residen	ice 6 Other	(Specify)
Bc. Injury at	28d. Describe how	v injury occurred	
1 Yes 2 No			
, office	28f. Location (Stre City or Town,	eet end Number Stete)	or Rural Route Number
at the time, date end pla	ace, end due to the cau	use(s) and mann	ner as stated.
, #1 my opinion, death or	correct at the time, dat	e and place, and	a due to the cause(s)
: License number	20.	d. Date signed (Month, Day, Year)
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H1587	250	7/28	5 1 2000
11587	231	7/28	12000
HI587		7/28	12000
auu auu au	26. Place of I Other: 4 Nursing c. Injury at Work? 1 Yes 2 No office the time, date end plan	23b. Dld tob 1 Yes 24a. Was an perform. 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Resider one of the control of the con	24a. Was an autopsy performed? 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other work? 1 Yes 2 No Office 28f. Location (Street end Number City or Town, Stete) the time, date end place, end due to the cause(s) and mann my opinion, death occurred at the time, date and place, and License number 29d. Date signed (



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State of Maryland / Department of Health and Mental Hygiene

			Certifica	te of Death	A	eg. No.	26310
Physician	1. Decedent's Neme (First, Middle, Last)				2. Date of Deal Month		3. Time of Death
/Medical	Paula Thibault				1	10°, 2000	12:00 Noon
Examiner	4a Facility Neme (If not institution, give str			4b. City, Town, or		4c. County o	
	Magnolia Hall Nursi			Cheste		Ken	
Funeral Director	077-14-0799	7. Age (In yrs. Ia 84	Yrs. Months	r 1 Yeer If Under 24 Hrs Days Hours Min.		3, 1915	9. Birthplece (State or Foreign Cauntry) Phillipines
nyland those	Usuel Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Location				10d. Inside City Limits
h the Marylar c 28e-f show undiffied at frector	Maryland Kent	Ch	estertown				1 Yes 2 No
or 28e-f	10e. Street and Number		10f. Z	p Code	1	0g. Citizen of W	hat Country?
4 52 H	207 Rolling Road			21620		USA	
art, or flams 23 Examiner mast by Funeral	11. Marital Status 12 11. Marital Status 12 12. Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes:		dent of Hispanic Origin? (Secify Cuben, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		- American Indian, s, White, etc. White
ed within 72 hours at spans. or than "natural", or it the Medical Exam Completed by F	15. Decedent's Educa (Specify only highest grade of		16a. Decedent's Usi (Give kind of w	ork done during most of wo	rking	16b. Kind of Bus	siness/Industry
mpi mpi	Etementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		Comment	
* BYER O	12 17. Father's Name (First, Middle, Last)	6	Computer	Programmer	me (First, Middle, I	Compute:	
d the sed of the sed o	Lorenzo Thibault			Elvira F			
To To	19a. Informant's Neme/Reletionship (Type	. Print)	19b. Meiling Addres	is (Street and Number or Ri		r, City or Town, S	State, Zip Code)
27 th at 72	Glenn Dulmage			Road, Chest			
a - Hand	20e, Method of Disposition	20b. Ple	ece of Disposition (Nemetery, crematory or	me of			City or Town, State
Pages 1 ant of 15 nt. if New ry or oth	1 Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	noval from State		ion Center, LLC	8/11/2000	Stevensvi	ille. Maryland
1 2 2 3	21. Signeture of Funeral Service Licensee		22. Name a	nd Address of Facility			
0 58118	1.11.			Helfenbein & N			
	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that caused the death.	. Do not enter the mo	er Road, Chester de of dying, such as cardia	c or respiretory arr	est,	Approximate
Physician	shock, or heart failure. List only one	ceuse on each line.					Interval Between Onset and Deeth
/Medical	Immediate Cause (Final disease or condition	SEPSIS					C. days
Examiner	resulting in deeth) a.	Due to (or	es a consequence of):	Z- 72		6 days 6 days
e e		PERITONI	TIS				6 days
executed in and intransit			as a consequence of	R	14.10		
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	SUSPECTE	ED 15C	HEMIC BI	OWEL		10 days
licate be physicial s the bu	that initiated events resulting in death) Last	Due to (or	as e consequence of				
= -	d.,						
attendin for usa							
. 0 .0	Part It. Other significant conditions contri			cause given in Part I.			tribute to the cause of death?
C X TI	ATRIAL FIBR	LILLATION			1 Y	es 200 No	3 Probably 4 Unknown
Physician: The law requires that this certificate has been signed brial director, page 2 should be determed to be completed by Pl	ATRIAL FIRM DIABETES ADVANCED	DEMISN	TIA		24a. Wes a perform		24b. Were autopsy findings available prior to completion of cause
has b		00111011					of deeth?
					1 🗆 Y	es 2 ANO	1 □ Yes 2 No
ysician: The secrificate director, pag	25. Was case referred to medical examiner?	spital:		Othor	ath (Check only or		
this cral din	1 Yes 2 No	1 Inpatient 2 E	ER/Outpatient 3□ □ 28b. Time of	OA Nursing I	dome 5 ☐ Resid	ence 6 Othe	
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Lat or Attending Physician: rs after death: all Director: After this certific led in by the funeral director, Certification: To Be (2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, facto		281. Location (S City or Town	treet and Numbern, State)	er or Rural Route Number,
To the Hospital or Attending Plywing 24 hours after death within 24 hours after death completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) (Check only one) (Check only one)	ian: To the best of my know r: On the basis of examinational and manner stated.	rledge, death occurre on and/or investigatio	d at the time, date and place n, in my opinion, death occi	e, end due to the curred et the time, d	ause(s) and mar late end place, a	nner es stated. ind due to the cause(s)
Me of the	29b. Signeture end title of certifier			c. License number	2	29d. Date signed	(Month, Day, Year)
FSFO	VVV	mum		D00415	87	8/	10/2000
	30. Name and address of parson who com				04.655		101-14
	Helen A. Noble 122			m, Maryland	21620		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure La	1			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 2:45 Bernice Elizabeth Turner 2000 /Medical August 4a. Facility Neme (If not institution, give street end number) Magnolia Hall 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Nursing & Convalescent Home Chestertown If Under 1 Yeer Months Deys if Under 24 Hrs. Hours Min. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthpleca (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Director 212-10-9031 12/28/1928 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be not hed at MD Kent Chestertown 15 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 207 Lincoln Drive 21620 U.S.A. Peges 1 and 2 should be filed within 72 hours after death tent of Heetth end Mental Hygiene. nt: If Item 27 is marked other then "naturef", or Itema 23. 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Rece - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 □ Divorcad Completed Be. Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businees/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Private Families 11th Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) David Johnson Irma Maker 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Karen Turner - daughter 139 Flatland Road, Chestertown, MD 21620 other 1 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetlon 3 □ Removel from Stete injury or Department of Important: If any injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) Janes Cemetery 8/7/00 Chestertown, MD 21620 21. Signeture of Funeral Servica Licenses 22. Name and Address of Facility James A. Perkins Funeral Service James a P. O. Box 143, 21106 Rock Hall Ave., Rock Hall Mg 2166 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximate nterval Between Onset end Deeth **Physician** SUSPECTED ARRHPITHMIA /Medical Immediate Cause (Final disease or condition resulting in death) < Imin Examiner HYPERTBUSIVE CARDIOVASCULAR DISOASE > 10 YS Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last P.O. Box 68760. Physician/Medical Due to (or es a consequenca of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown DIABBIES Records, P ATMAC FIBRILLATION 24b. Were autopsy findings avellable prior to completion of cause of deeth? PERALINSUFFICIENCY DISGASE Completed 24e. Wes an autopsy performed? peed 2K No 1 ☐ Yes No certificate Division of Vital 25. Wes case referred to medical examiner? 28. Placa of Death (Check only one) Other: 45 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Megner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Netural 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and menner as stated.

— Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and piace, and due to the cause(s) end menner stated. 29e. Certifier Medical 29b. Signeture; end title of certifier 29d. Dete signed (Month, Dey, Year) D0041587 122 Speek Rd Suite 5 Chestextoun Md B. Sparks 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) Flelen A M 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State AUG 4 2000 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Data of Death 2000 Willet August 1550 James Robert 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) 2644 Tyrone Road Westminster Carroll County If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 10 M 2□ F Months Days Hours Yrs 218-64-3456 47 Aug. 4, 1953 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll County Westminster 1 ☐ Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21158 United States 2644 Tyrone Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) painting contractor painting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) Ethel R. Rill Robert D. Willet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nora A. Willet / wife 2644 Tyrone Road Westminster, MAryland 21158 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Aug Pate 7 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 2000 Smithsburg, Maryland Smithsburg Crematorium 21. Signature of Funeral Servica Licensee 22. Nama and Addrass of Facility Skiles Funeral Home M01072 136 East Baltimore Street Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequence ot) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca ot): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yee 2 No 3 | Probably 4 | Unknown 24b. Were autopsy tindings available prior to completion of cause ot death? 24a. Was an autopsy performed? 1 Yee 2 No 1 Yes 2 No

Physician /Medical Examiner

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Box 68760.

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Division of Vital Records.

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item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Medical Examination must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or ite

altimore, Maryland 21215-0020

Examiner Physician/Medical P Completed

25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1- Natural 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide

28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) manner stated. 29a. Certifie

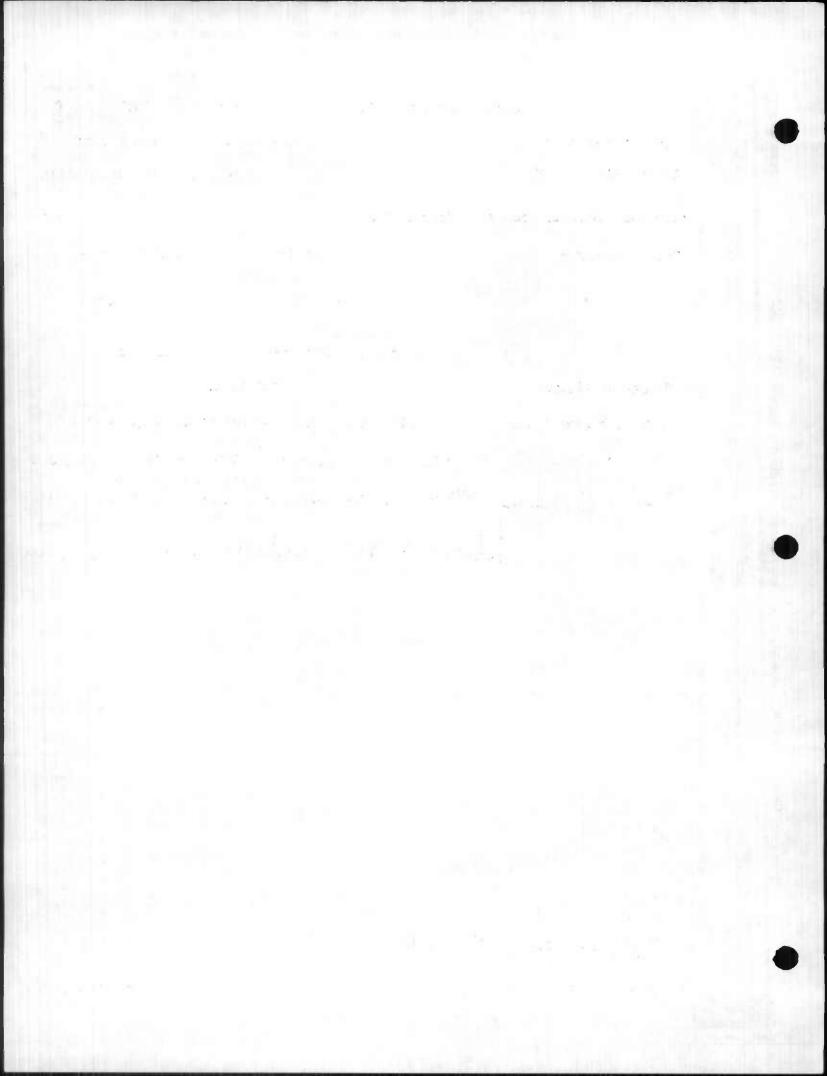
29b. Signature 29c License number 29d. Date signed (Month, Day, Year) title of cartifier

completed cause of death (Item 23a) (Type, Print)

ANUG 0 8 2000

224 Washington Heights Westminster, MD 21157 awo 31. Date tiled (Month, Day, Year) 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 5 Wolfe Helen Janet 2000 1910 August 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4921 Feeser Road West Taneytown Carroll County If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Months Days 1 M 2 F Yrs. 211-34-8012 55 Mar. 2, 1945 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a Stata 10b. County 10d. Inside City Limits 1 Yes 2 No Taneytown Maryland Carroll County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 United States 4921 Feeser Road West 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) publishing house shipping clerk 9 18. Mother's Neme (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Bernadette Josephine Gephart Joseph Edward Krichten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Taneytown, MD 21787 4921 Feeser Road West Donald N. Wolfe/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Aug. 9 Keysville Union Cemetery Keymar, Maryland 2000 21. Signature of Funeral Service Limit 22. Name and Address of Facility Skiles Funeral Home MO0534 iles MD 21787 136 East Baltimore Street Taneytown, 23a. Part. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case relerred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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7 is merked other than "natural", or items 23s or 28s-1 show trsumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Haalth and Mentel Hyglene. Important: if Item 27 is marked other than "natural", or then any injury or other traumatic event.

Baltimore, Maryland 21215-0020

Box 68760,

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death

Examiner physician end the buriel-trensit 80 for use page 2 s

Physician/Medical þ Completed funaral director, Be To Certification:

requires that the death certificate be axecuted signed by the a d be detached f has certificate

Division of Vital Records, P.O. Hospital or Attending Physician: After this efter death. filled in by 24 hours e

Registrar

Medical

29b. Signature

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within 2 To the

28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of exeminetion and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier (Check only one)

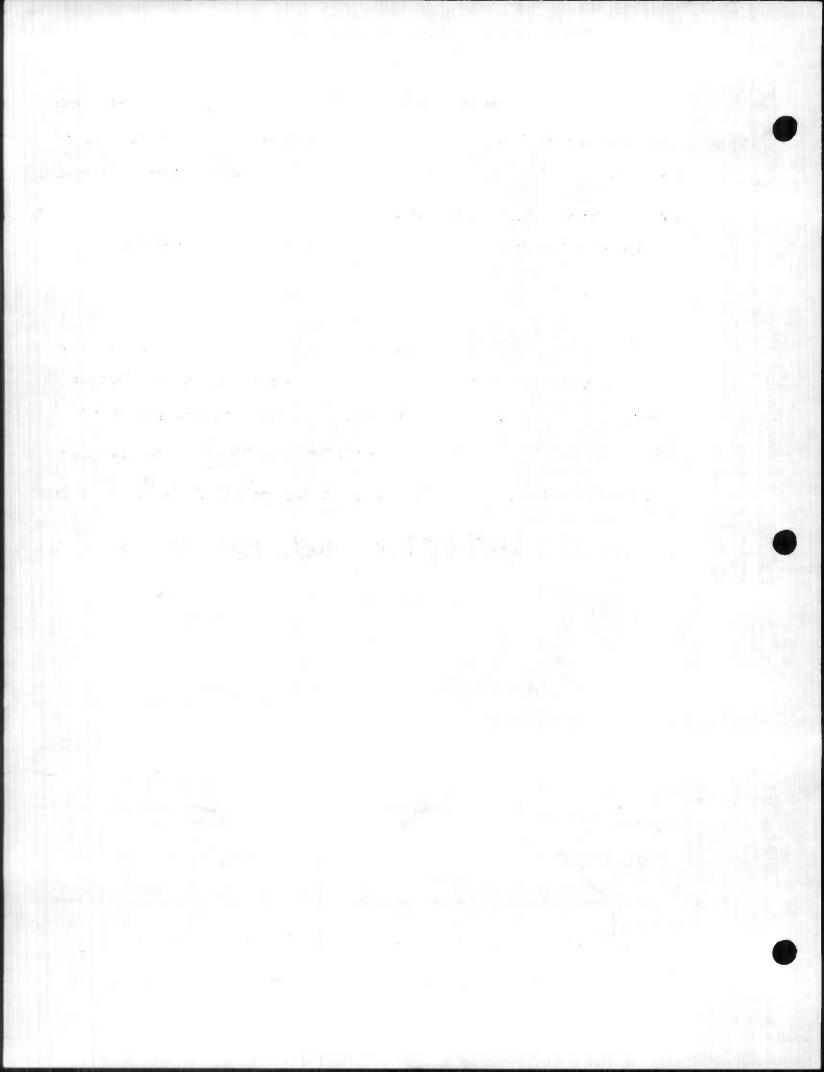
29d. Date signed (Month, Day, Year) 29c. License number

cause of death (Item 23e) (Type, Print) 30. Name and address of person

ashington Heights Westminster, MD 21157 31. Date filed (Month, Day, Year)

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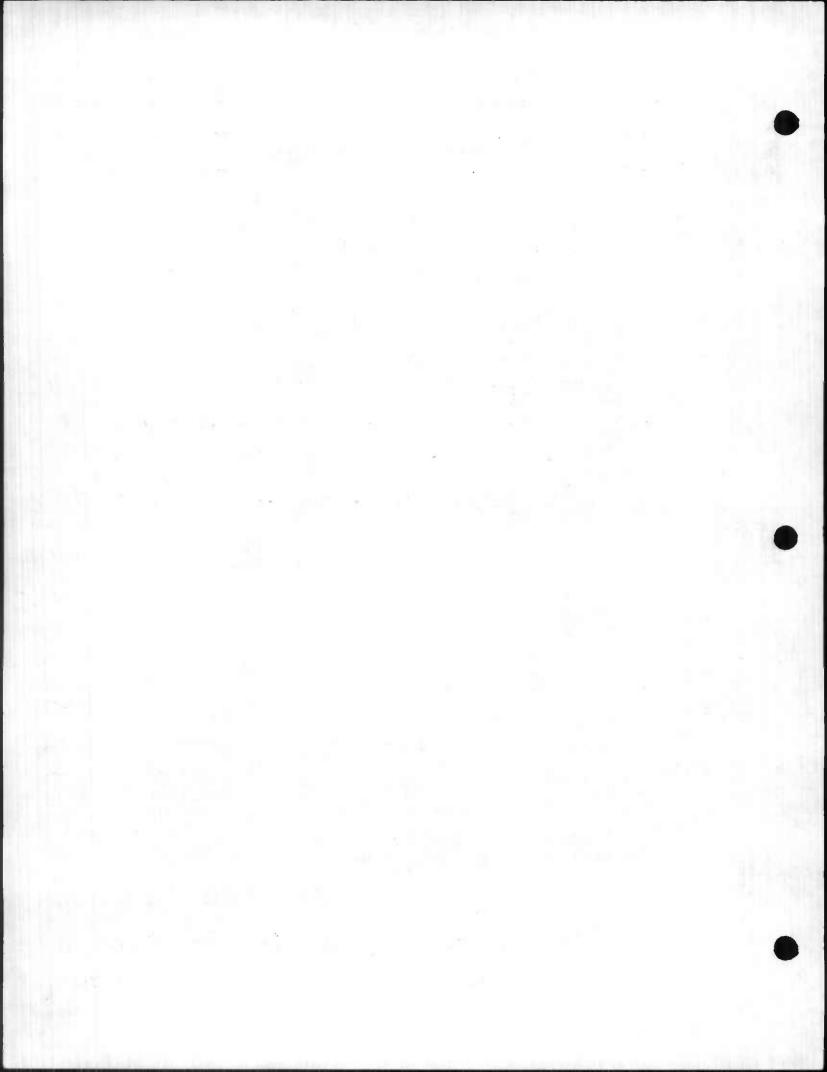
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death 08-03-2000 **Physician** 10:15 PM Betty Elizabeth Wisner /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Genesis Randallstown Randallstown Baltimore If Under 1 Yaer If Undar 24 Hrs. B. Data of Birth (Month, Day, Year) 07-16-30 Birthplaca (Stata or Foraign Country)
 MD 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Hours 10 M 35X 70 212-30-6374 Yrs. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Manylan nest of Health and Mental hygiene.
Intst if tem 27 le marked other than "natural", or items 23a or 28e-1 ahow my or other traumatte event, the feed of the traumatte or notified inty or other traumatte event, the feed of the traumatte or notified in 1 ☐ Yes ŽQNo Baltimore Boring 10e. Street and Number 10f. Zio Coda 10g. Citizen of What Country? 14723 Old Hanover Road 21020 US Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Never Married 3 Married 1 ☐ Yas XXNo If Yas, Giva Baltimore, Maryland 21215-0020 1 Yas 200 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) 8 Margaret Elizabeth Poole Carroll Elwood Palmer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Robert E Wisner SR, spouse 14723 Old Hanover Road, Boring, MD 21020 20b. Place of Disposition (Name of cematary, cramatory or other place)
Mt. Zion UMC 20a. Method of Disposition 20c. Location - City or Town, Stata Data XX Buriaf 2 Cremation 3 Removel from Stata permit. Page Department of Important: If any Injury or page. 08-07 4 ☐ Donation 5 ☐ Other (Specify) Upperco, MD 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funaral Service Licensee 934 S. Main St., Hampstead, MD 21074 23a, Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final rummer diseasa or condition resulting in death) Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or figury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): for usa P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 Yes 2 YNo Division of Vital or Attending Physician: funeral director, 8 25. Was case refarred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending investigation death. 1 Yas 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and dua to the cause(s) and mannar as stated. Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of (Illem 23a) (Type, Print) 31. Data filed (Month, Day, Year) State AUG 08

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	Decedent's Nama (First, Middle, La.	•	Cen	ificate of	Death	2. Date of Dea	eg. No.	1 2	3. Time of Death
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/Medical Examiner	And Providence Administration of the administration of the	street and number)			4b. City, Town, or L		4c. County		
	Kent and Queen Ann				Chester			Kent	
Funeral Director	5. Social Security Number 6. S 027–28–2100 Susual Residence of Decedent	ex 7. Age (In yrs 69	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey September	7, 1930	9. Birthpla Countr Delaw	nce (State or Foreign y) Tare
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£ 5 5	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Countr	y?
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Galtimore, Ma semit. Pages 1 and 2 Separtment of Heelth at myortant: If Itam 27 is iny injury or other trai	20a. Method of Disposition	20b.	Place of Disposi cemetery, creme	tion (Neme of		6, ^{Date} 2000	20c. Location -		
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permit. Page Department of Important: If any injury or once.	21. Signature of Funeral Service Veer	gref N a.	22.	Name and Addre	ss of Facility				
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State of Maryland / Department of Health and Mental Hygiene 253 | 6

Certificate of Death

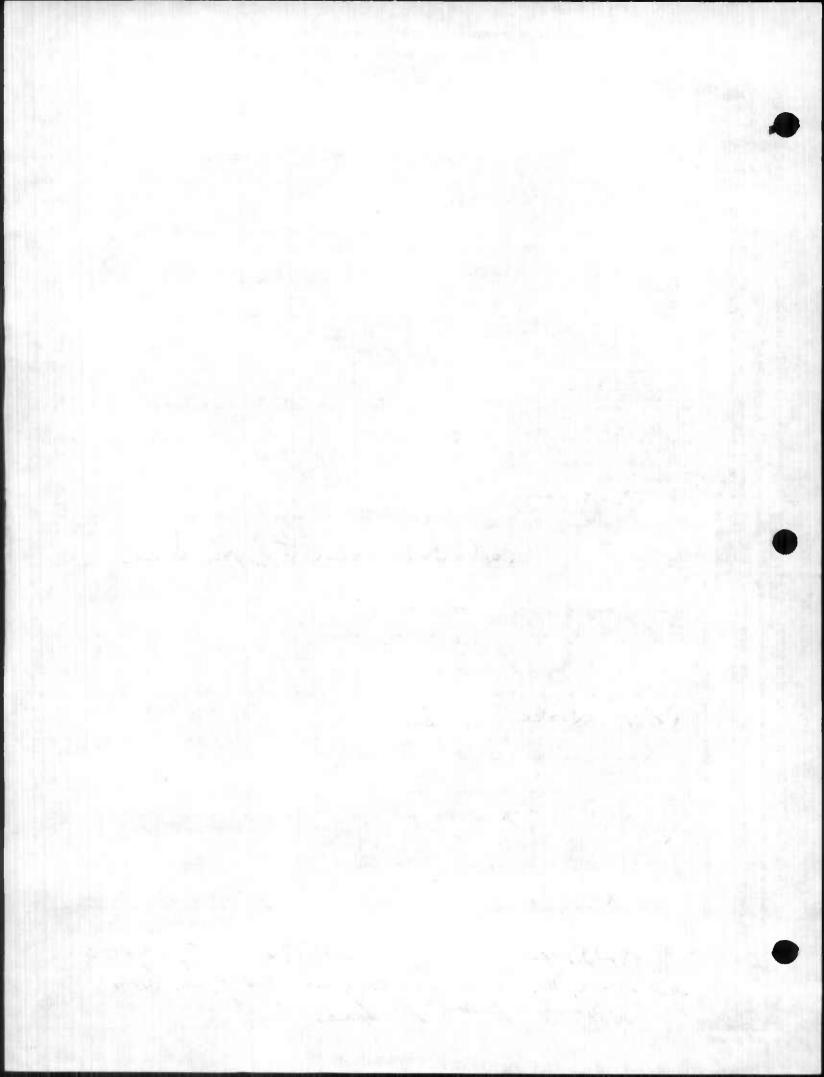
2 Date of Death

3 Time of Death

						Ce	rtifica	te of	Death			leg. No.			
	Dhusisian	1. Decedent's Nam									2. Date of Dea Month	th Day	Year	3. Tima of De	eath
Q.	Physician /Medical	Robert	Holland	Workman							July	26, 2	,000	055	5
	Examiner		LA REGIO			ENTER			SAL	ISBU	ocation of Death		y of Death		
Ш	Funeral Director	5. Social Security N 221-18-82	.58	Sex 1MM 2□ F	7. Age (In yr	71 Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Dete of Birti (Month, Pay July 14	, 1929	9. Birthp Cour DE	plece (Stata or F	Foreign
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	h with the Mar 3a or 28a-f al 1 be noutled al Director	10e, Street and Nu 30512 N	mber lutter's	Lane		7.7	10f. ZI	Code 218	353			10g. Citizan of USA	What Cour	itry?	
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	ine law requires that sate has been signed b page 2 should be dete Completed by PI			,							24a. Was perfo	an eutopsy med?	av	era autopsy find railable prior to empletion of cau death?	
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KOBERT H. WORKMAN

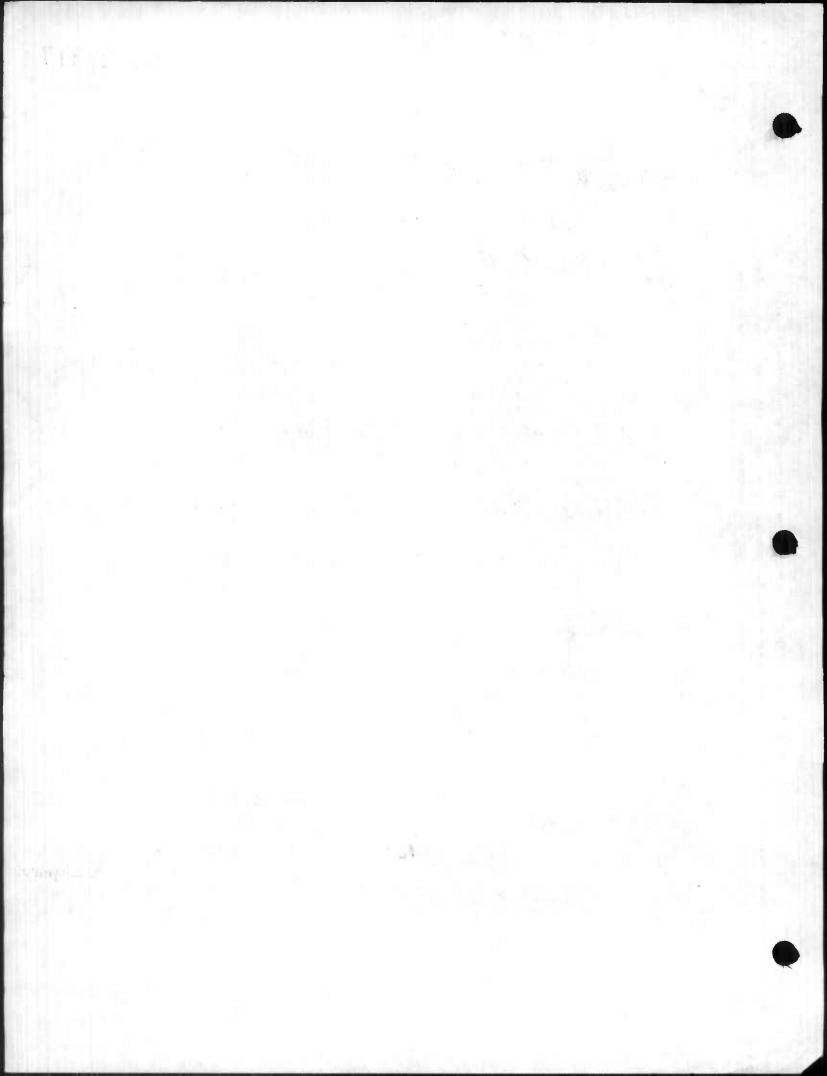


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

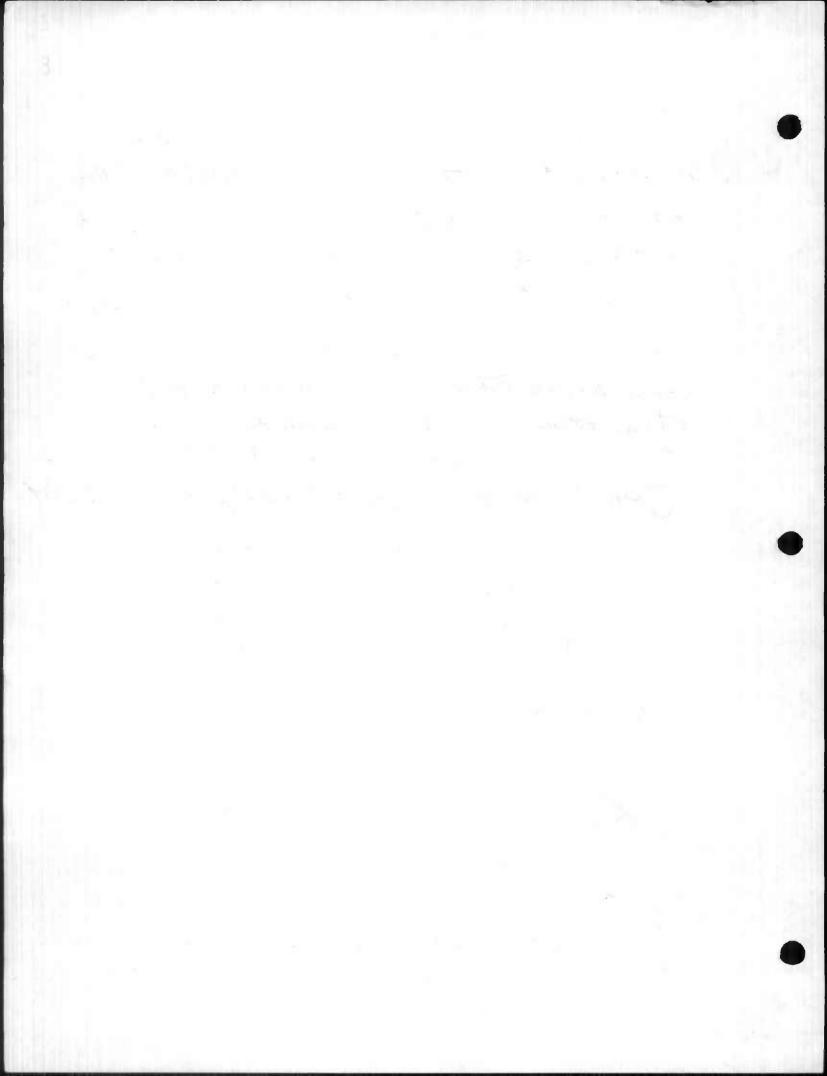
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-	Physicia /Medic		Silvey L). Durnes) 10,		AUGUST	16,	2000	2140 PM
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	m		J'MY	100				1	., -	
			30. Nama and address of person who co	omplated causa of death (Itam 23a) (Ty		Raltimom	Marvil	and 2120	1	
	Stat	0	31. Data filed (Month) Pay, Year)	32. Registrar's Signature	n Street,		, ratyla	IKI ZIZU	1	
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Funeral Director		17/8 E. 29 M D 5. Sociel Security Number 6. Sex 242 24 6988 18 M 2 F	7. Age (In yrs. last birt	hdey) If Under 1 Yeer Months Deys	Bollo. If Under 24 Hrs. 8. Hours Min.	Dete of Birth (Month, Dey, Y	N A 9. Birth	hplece (State or Forei
Maryland f ehow	tor	Usual Residence of Decadent 10e. Stete 10b. County N A N A	10c. City, Town					10d. Inside City Limi
death with the Maryland rns 23a or 28a-f ehow	Funeral Director	10e. Street end Number	0 (31	10f. Zip Code 2/2/8			. Citizen of Whet Co リ・ケ・カ	untry?
or its	by Funer	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Dec Armed For Individual Stephen	2 No	13. Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Reca - Ame Bleck, White Specify:	
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	during most of working d)		ED. Kind of Business	Industry
Mental Mental arkad c	To Be C	17. Fether's Neme (First, Middle, Last) JAMES MANUEL B	ethea		18. Mother's Neme (F	First, Middle, Me	Her N	
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within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29b. Signature end title of certifier	ner stated.	29c. Licens	se number	A		h, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day Year **Physician** DOROTHY august BADART 2000 12.3000 16 /Medicai 4b. City, Town, or Location of Death 4a. Facility Name (ff not institution, give street end number) 4c. County of Death **Examiner** N/A Keswick Multicare Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Steta or Foraign Country) **Funeral** Days Months 1 M SELF Hours 92 212.01.1605 Yrs Director Nov.30,1907Colorado Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified at 28a-f show Yes 2□No Director N/A Baltimore 10e Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 700 W. 40th Street 21211 Funeral 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritai Status 14. Race - American Indian, Black, White, atc. 1 ☐ Yes 2 X No If Yes, Give Yaar or Dates: 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No White þ Specify: XIXWidowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grede complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Heelth and Mental Hygiens Important: if I tem 27 is marked other than in any Injury or other traumatic evens Elementary/Secondery (0-12) College (1-4or 5+) * Construction Executive Secretary Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Elizabeth Gibson Ferd Strouse 19a. Intermant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zlp Code) Alexis Bodart/Brother in law 6001 Old Lawyers Rd. Elkridge, MD 21075 Baltimore, 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Ramoval trom State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/19 Beltsville, MD 21. Signature of Funeral Service Light 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge Mem. Park 7250 Washington Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete interval Between Onsat and Death **Physician** /Medicai Immediate Cause (Final anema disease or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner bleedin The law requires that the deeth certificate be executed buriel-transit Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last pue Box 68760, physician Physician/Medical the Due to (or as a consequenca ot): the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? s been signed by to should be detech alsheemer's 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. à 24b. Were autopsy tindings available prior to completion of causa ot death? Completed 24a. Was an autopsy performed? certificate 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 28. Plece of Death (Check only one) Other: 4 Nursing Homa 5 ☐ Rasidenca 8 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral c 27. Manner of Deeth 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 8 Could not be datarmined 3 Suicide 28t. Location (Street end Number or Rural Routa Number, City or Town, Stefa) 28e. Place of Injury - At home, tarm, atreet, factory, office building, atc. (Spacify) À 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b 29a. Certifier (Check only one) edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M Habelle Vac august 16,2000 Green 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

KERWICK MULTICARE COWDR. BALTIMORE, M) 21211

DHMH 16 Ray 6/95

State

Registrar

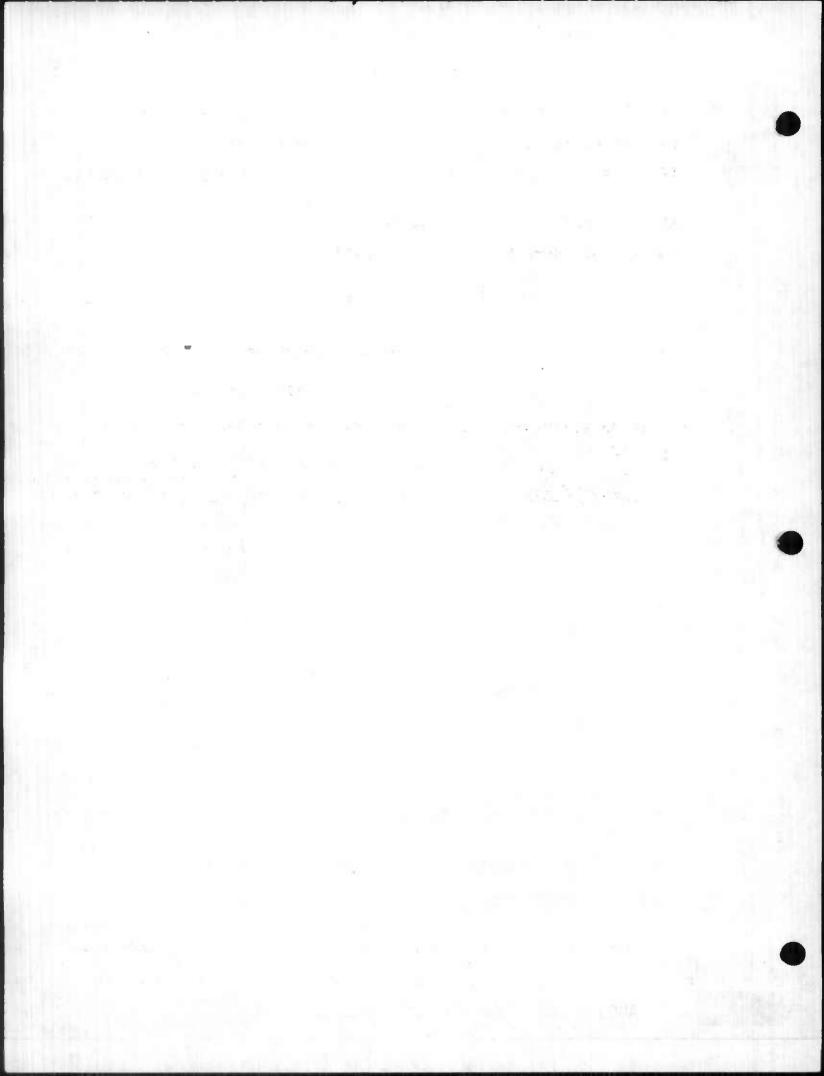
MESABELLE MACGREGOR.

AUG 2 1 2000

32. Registrar's Signature

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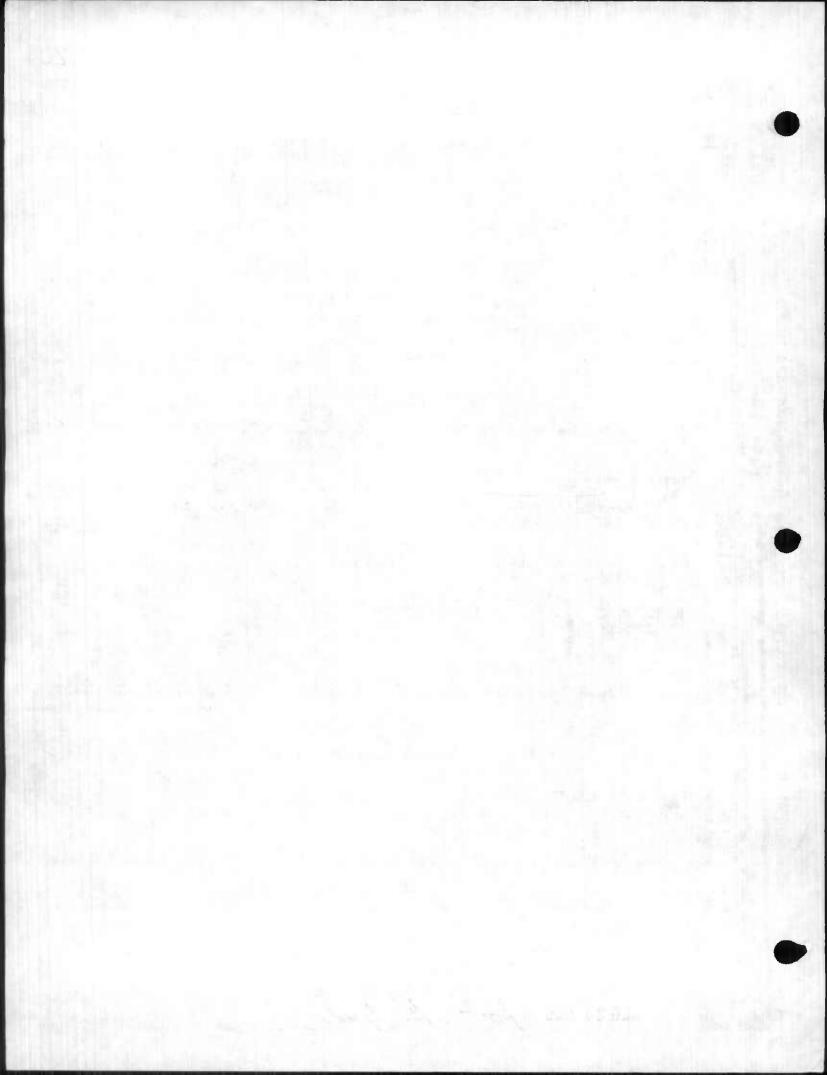
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State of Maryland / Department of Health and Mental Hygiene 00 26320

		C	ertificate of Death	Reg. No.	20060
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Physician /Medical	PERCV	ANDREW	BROWN	1 - 1 -	000 1:00 F
Examiner	4a Facility Neme (If not institution, give		4b. City, Town, or L		
Funeral Director	5. Sociel Security Number 6. Se 218 - 48 - 0450	3AL ROAD 7. Age (In yrs. last birthda M 2DF 53 Yrs.	Months Days Hours Min	LSTOWN BA 8. Date of Birth (Month, Dey, Year) APRIL 24, 1947	LTIMORE 9. Birthplace (State or For Country) GERMANY
3	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Lir
th with the Meryland 23a or 28a-f show at be notified at al Director		TIMORE GAL ROAD	RANDALLSTO	10g. Citizen of W	1 (X) Yes 2 □
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by C.	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	1 Yes 2 SNo Specify:	Specify	BLACK
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If Hygiene. other than " vent, the Me.	Elementary/Secondary (0-12) 12 +HGRADE 17. Fether's Neme (First, Middle, Last)	College (1-4or 5+)	ive kind of work done during most of work. BONOT use retired) REHOUSE SUPERV. 18. Mother's Nan	I.SOR. LANDSO	9)
Menta Menta Menta To	STERLING	Jo	ONES ALICE	E J	ACKSON
thant of Heal	19e. Informent's Neme/Relationship (7. YOLDNDA BROW 20a. Method of Disposition 12 Surial 2 Cremetion 3 DI 4 Donetion 5 Other (Specify,	Removel from State 20b. Plece of Discemetery, Company, C	eiling Address (Street and Number or Ru GILLAND COUR sposition (Neme of cremetory or other place) LAWN CEMETERY (T NOTTINGHA Dete 20c. Location - 18-19-00 BALT	MMD, 212 City or Town, Stata
any II	1 John total	tras	22. Name end Address of Fecility JOSEPH H. BA 2140 N. FULTO enter the mode of dying, such as cardiac	NAVE. BALTO	JERAL HOM , MD. 212
ng physician and as the burishransit wedical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	b. Due to (or as a conductor) Due to (or as a conductor) Due to (or as a conductor) Due to (or as a conductor)	sequenca of):		6/00
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as been sign 2 should be pleted by				24a. Was an autopsy performed?	24b. Were autopsy findin available prior to completion of cause of death?
certificate rector, pag	25. Was case referred to medicat		90 Diagraf D.		10 105 20 NO
this certificate har all director, page	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othor	ome 5 Residence 6 □Othe	ar (Specify)
fer th neral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	e of 28c. Injury at	28d. Describe how injury occurr	
to the Propriet of Attentions of Within 24 hours after deeth. To the Funeral Director: After the Completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At home, ferm, building, etc. (Specify)	street, fectory, office	28f. Location (Street and Numb City or Town, Stete)	er or Rural Route Number,
n 24 hour Ne Funer pletaly fills edical	29a. Certifier 1 S Certifying Phy (Check only one) 2 Medical Exam	alcian: To the best of my knowledge, de ner: On the basis of exemination and/or and menner stated.	eath occurred at the time, dete end plece r investigation, in my opinion, deeth occu	, and due to the cause(s) end ma rred et the time, date and place, a	nner es stated. and due to the cause(s)
Within Comp	29b. Signeture and title of certifier	1	29c. License number	29d. Dete signed	(Month, Day, Year)
0	KAWali	MOMO	D38662	8/18	100
m 13	30. Name and address of person who co Richard J. Wal	completed cause of deeth (Item 23e) (Typesh 4660 Wilke	ne Print)	EMD 212	29
State Registrar	31. Date filed (Month, Dey, Year) AUG 2 1 2001	32. Registrer's Signeture	Some V.		



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State of Maryland / Department of Health and Mental Hygiene

26321 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeih 3. Time of Death Day Month **Physician** Charles Edwin August 18, 2000 Besore' 8:20 a.m. /Medicai 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Cockeysville Baltimore If Under 1 Year if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Ye Jan. 30, 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 100 M 2□ F Days Year) 214-05-0628 Yrs. Director 92 Md. Usuai Residence of Decedent the Marylend 10a Siete a or 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limiis 1 ☐ Yes 2 ☑ No Director Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 13801 York Rd. 21030 USA Funeral death Hems ? 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marijel Siaius "natural", or item filed within 72 hours effer 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedeni's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Induatry Hygiena. than Elementary/Secondary (0-12) College (1-4or 5+) 12 i. Peges 1 and 2 should be filed w tmant of Health end Mental Hygier tant: If Itam 27 Is marked other th jury or other traumatic event, the Sales Representative Allied Cordage Co. 17. Fether's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) Be Alpheus Neander Besore Mills 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jessie H. Besore /wife 13801 York Rd. Apt. L-2 Cockeysville, Md. 21030 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removei from State Depertment of Important: If any Injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) 8/19/00 Hilltop Service Corp. Towson, Md. 21204 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each time. Approximate Intervel Between Onsei and Death **Physician** cerebral Blus /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): certificeta be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): -bunal-P.O. Box 68760, Physician/Medical 4 Due to (or as e consequence of): use as The law requires that the death for signed by the a Part Ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use centribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. 79 Completed 24a. Was en autopsy performed? 24b. Were autopsy findings evelleble prior to peen completion of cause of death? page 2 certificate 2 No 1 ☐ Yes 2 ☐ No Physician: director. 25. Was case referred to medical Be 26. Piace of Death (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 28a. Date of injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? Aftar 1 DiNeturei 5 Pending investigation if or Attending s efter deeth. 1 Yes 2 Accident in by the 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide filled the Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and piace, and due to the cause(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signaturg and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item.

DHMH 16 Rev 6/95

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31. Date filed (Month, Day, Year)

AUG 2 1 2000

32. Registrar's Signature

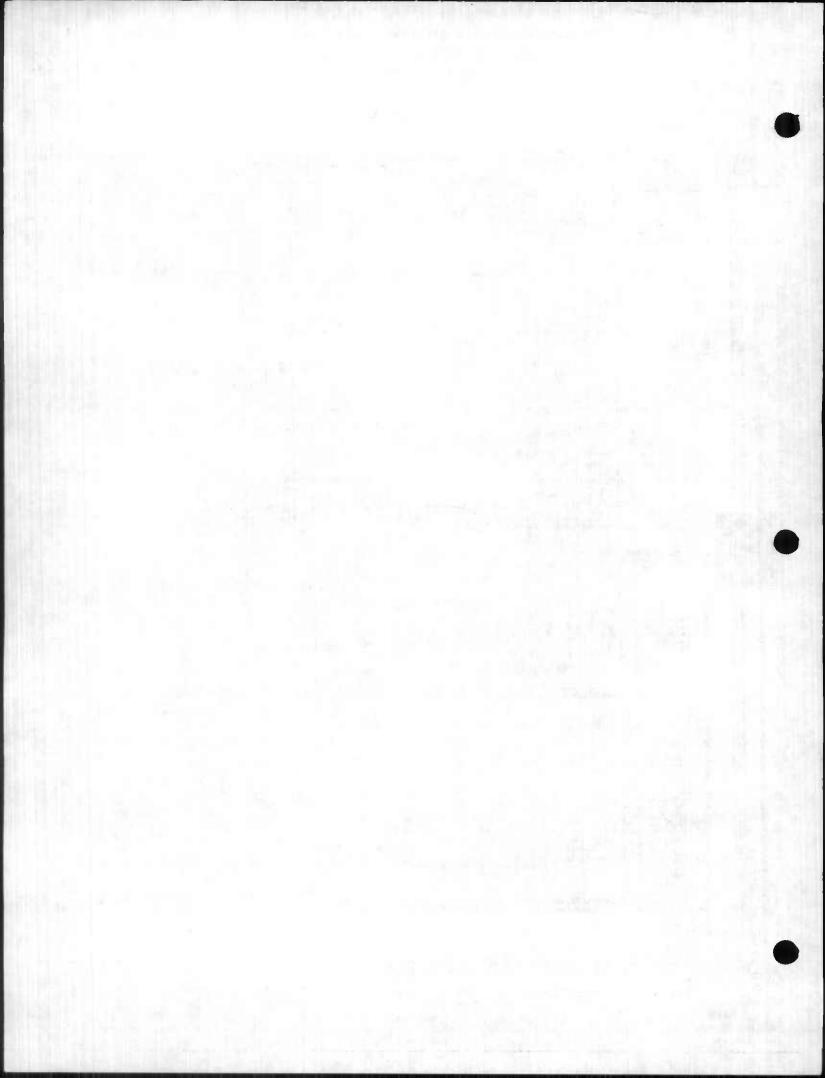


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State of Maryland / Department of Health and Mental Hygiene

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			C	ertifica	ate of	Death		Reg. No.	10	20322
Dh. alain.	1. Decedent's Nama (First, Middle, La.	st)	n Maria				2. Date of De Month	ath Day	Year	3. Tima of Death
Physician /Medical	СННАВІ		BH	IUSHAN			AUGUST	16 20	000	21:02
Examiner	4a Facility Name (If not institution, giv-					4b. City, Town, or	Location of Death	4c. County	of Death	
	THE JOHNS HOPKING 5. Social Security Number 6. S		yrs. last birthd	av) If Unc	iar 1 Year	BALTIMOI If Under 24 Hrs		th	9. Birthol	lace (State or Foreign
Funeral Director		M	55 Yrs	Month	s Days	Hours Min		1935	Ind	ia
dand war	10a. Stata 10b. County	10	c. City, Town or	Location					10	Od. Inside City Limits
Many	Md. Baltimore		Hunt Val	ley						1 ☐ Yes 2 💢 No
h with the Mar 13a or 25a-f s 11 or notified al Director	10e. Street and Number 33 White Pine Ct.			101. 2	Zip Code 21030)		10g. Citizen of \	What Coun JSA	lry?
within 72 hours after death with the Maryland within "natural", or thems 23s or 28s-f show the Medical Exercises must be notified at ompleted by Funeral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evan Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas:	in U,S. 1		cedent of Hopecify Cubi	lispanic Origin? (San, Maxican, Puer Specify:	Specify Yas or No to Rican, atc.)	Blac	e - Amarico ck, White, o	etc.
d within 72 hours at giene. In Medical Exercises Completed by R	15. Decedent's Ed (Specify only highest gra		16a. De	cedent's Us	sual Occup work done	etion during most of wo	rking	16b. Kind of B	usiness/Ind	lustry
filed within 72 ho Hygiene. Wher then "natura ent, tre Medical	Elementary/Secondery (0-12)	College (1-4or 5+) +20		cal Doo		d)		Medic:	ine	
	17. Father's Neme (First, Middle, Last)		11001			18. Mother's Na	me (First, Middle,	, Meiden Sumen	10)	
should be filed nd Mental Hygi marked other umetic event, I	Mahavir Prasad				10	Lalita	Kunwar			
d 2 should be file th and Mental Hy 7 is marked other treumatic event	19e. Informant's Name/Relationship (Type, Print)				end Number or R				Code)
C TO N L	Mr. James E. Guy/ PR					own Rd. #10				
bernit. Pages 1 ar Department of Hee Moortant: If Item; Iny Injury or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific		Cib. Place of Dicametery,				Date 8-21-00	Towson,		wn, State
permit. Page Department of Important: If I any Injury or once.	21. Signature of Funeral Service Licer	1		Ruck	k Tows	on Funeral				
	23a. Part1. Enter the disease shock, or heart failure. Unit only	lications that caused the	death. Do not	enter the m	J YONK lode of dyli	Rd. Towson	n, Md. 212 c or respiratory a	rrest,		Approximate Interval Between
Physician	shock, or heart failure. Effit only	bne cause ow each line.							1	Onsat and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	aASY	STOLE							FIVE MINUTE
<u> </u>	Tooling it county		to (or as a con			EASE			300	TWENTY YEAR
ate be executed hyssician and the buriel-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or Injury	b. Due	to (or as a con	sequenca o	of):		16 9			
Page 4	Ceuse (Disease or Injury that Initiated events resulting in death) Last	c. Dua	to (or as a con	sequance o	f):					
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requir been s should								an autopsy ormed?	COI	ere autopsy findinga silable prior to mpletion of causa death?
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his his	axaminer? Nas 2 No 27. Manner of Death Natural 5 Pending	Hospital: 1 Inpatient 28e. Dete of Injury (Month, Day Ye	2 ☐ ER/Outpa 28b. Tim Inju	e of	28c. Inju Wo	ry at rk?	Home 5 Resi	dence 6 DOth		у)
tal or Attanding P rs after death. al Director: After t led in by the funers Certification:	Accident investigation 3 Suicide 6 Could not be determined		At home, term	, street, fact		Yes 2 No	28f. Location (City or To		ber or Rura	il Route Number,
To the Hospital or Atland within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifiar 10 Certifying Ph	ysician: To the best of ni niner: On the basis of exa and manner stated.	y knowledge, d mination and/o	eath occurre r Investigati	ed at the ti	me, date end plec opinion, death occ	e, and due to tha urred at the time,	cause(s) and m date and place,	anner as si and due to	tated. o the cause(s)
Med Med	29b. Signature and title of certifier	and manner state().			29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)
1h	Peter J.	Seular	mo		J	RES-000		AUGUST		
8KV	30. Nama and address of person who Pater J. Gru	completed causa of death	(Item 23a) (Ty RTH WOI		REET	BALTIMO	ORE, MAR	YLAND 3	21287	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrads		,						



MICHAEL BERTI Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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MEND THEM	CT 422	DADM	т	27	203 17	PER MEQ	G186 8-28-	00 WR.

AMEND	1	TEMSL #23 PART	I, 27, 287	A-F Cer	thicate of	Death 28-	·00 WR	Reg. No.	10 2	6323
Physicia		1. Decedent's Neme (First, Middle, Le	0()				2. Date of De Month	Dey Dey	Yeer	3. Time of Death
/Medic		Michael Anthon				4b. City, Town, or Lo	AUGUS			2110 PM
Examin	er	4a Facility Name (If not institution, gived 6201 EUNICE AVE						N,		
Funeral		5. Social Security Number 6. S		yrs. lest birthday)	If Undar 1 Yaar				9. Birthplec	e (Stete or Foreign
Puneral Director				27 Yrs.	Months Days	Hours Min.	8. Dete of Bir Month De Aug. 22	,1972	Country	nd
mat be notified at		10a. Stete 10b. County	100	c. City, Town or Lo	cation					Insida City Limits
100	ctor	MD N/A		Baltimore	9	2.1				XX Yas 2 No
a or 28a-f show be notified at	Directo	10e. Street and Number			10f. Zip Code 21214			U.S.A		1
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if, or item Contribut.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cub	Hispanic Origin? (Spean, Maxican, Puerto Specify:	Rican, etc.)	Blac Specify	ck, White, etc.	
Icel	pet	15. Decedent's Ed	ucation	16a. Deced	dent's Usual Occup	pation	ina	16b. Kind of B	usin ess/Indu s	try
- Feb	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worki	ny .	Death		
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90 00	Be o	17. Father's Name (First, Middle, Last) Joseph Anthony Be	nti			18. Mother's Name JoAnne N		, Maiden Surnen	10)	
mark	70	19e. Informent's Name/Relationship		19h Mailir	nn Address /Stree	end Number or Rura		er City or Town	State Zin Co	ode)
treus		JoAnne Dehaghi - M				Avenue Bal				
othe		20a. Method of Disposition	2	Ob. Place of Dispo			Dete	20c. Location -		
世古		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from Stata	Oaklawn (/21/00	Baltimo	re. Ma	rvland
orta		21. Signature of Funaral Sarvice Licer			. Name end Addre	see of Eacility		Ruck, I		Jadiid
E S S		1 Leash	. (-	9	305 Harfo			ore, Mar		21214
		23e. Pert1. Enter the disease, or com shock, or heart failure. List only	picetions that causad the			ng, such as cardiac	or respiretory e	errest,		pproximete tervel Between
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To the Funeral Direct completely filled in by	edical		ysician: To the best of my ilner: On the basis of exa and manner steted.							
Toth	×	29b. Signature and title of certifier			29c. Licen			29d. Data signe		
		910	N. The		O.	ME		AUGUST	18, 20	00
4		30. Name and address of person who		(Item 23a) (Type,	Print)					
I		JACK M. T.	TUS MID	111 Don	Street	Raltimor	m Mam	rland 21	201	

State Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year)

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32. Registrar's Signatura

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n JEAN		Manager 1		BALB	OS				A WCh	16 ^{Pay}	2000	5AM
4a Facility Neme	(If not institution, gi		ber)				4b. City, To BALTI		cation of Deat	4c. Cour	nty of Death	
5. Sociel Security	Number 6.	Sex 7.	. Age (In yrs.	last birthday,	If Under 1		If Under:	24 Hrs.	8. Date of Bir	th	9. Birth	place (State or I
053-16-6 Usuel Residence	0337	10 M 2/0 F	78	Yrs.	Months	Deys	Hours	Min.	9/21/1	921	BROO	KĽYN, N
10a. Steta MD	N/A			y, Town or L CIMORE								10d. Inside City 1 X Yes 2
10e. Street and N 7503 Pi	lumber ARK HEIGH	TS AVE			101. Zip C					10g. Citizen o		intry?
11. Meritel Stetus		12. Was Deced		,S. 13.			lispenic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		ace - Ameri leck, White	
N Widowed	arried 2 Merried 4 Divorced	1 Yes 2 If Yes, Give Yeer or Date	No No		1 ☐ Yes 2		Specify:	, r derio	Thoan, etc.,	100	eify: WH	
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17. Fether's Nemo	e (First, Middle, Las	t)				-9-		r's Neme	(First, Middle	Maiden Surn	ame)	
JOSEPH	Neme/Reletionship	(Type Print)		19b Mail	LEVY		IDA	or or Run	al Route Numb		KNOWN	
	BAND/DAUG								OWINGS			
20a. Method of Di	isposition 2	Removal from St	ate C	emetery, cre	osition (Name matory or oth	her plac	ce)		Dete (2.0	20c. Location		
4 Donetion	5 Other (Speci	ify)	HE		OUNG M. 2. Name and				/18/00	BALTIM	ORE,	MD.
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State Registrar

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AMEND ITEMS: #20B, 22 PER F.H. G/86 8-19-00 WR. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dets of Deeth 3. Time of Death Month **Physician** Blackmon 6: 29 AM Joseph August 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, give street and number) Examiner Baltimore Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) 6. Sex 1X M 2 F 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys 219-40-8772 Usual Residence of Decedent Yrs. Director the Manyland 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental hygiene. I have 12 marked other than "natural", or items 23a or 28a-f show other traumatic avent, its latestall Emerican mail to notive 3. 1 Yes 2□ No Md Funeral Director NI SIMMI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced ac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Paintenance 10 45 18. Mother's Neme (First, Middle, Meidan Sumema) 17 Fether's Nema (First, Middle, Last) Be Pages 1 and 2 should be finant of Health and Mental I and: If I ham 27 is marked of Blac 1040 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Coodwar redera Jer 1126 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or of phose. 1 Buriel 2 ☐ Crametion 3 ☐ Ramovel from State CEMETER'S-21-2000 Belt worse 4 ☐ Donation)5 ☐ Other (Specify) 21. Signature of Funarel Service Ligense 23a. Penti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 22. Neme end Address of Fecility 1639 N. BROADWAY Baltimore, Maryland Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting In deeth) /Medical Sepsis One Day Examiner Due to (or es e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burishinans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Due to (or es a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4% Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical Be 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Medical Certification: al or Attanding P saftar death.

I Director: After the in by the funers 5 Pending invastigation 1 Netural Injury 1 Yes 2 No 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b 152 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner steted. 29e. Certifier 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier August 17, 2000 RES-000 600 North Wolfest. 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Hunter Champion Baltimore MD 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State parks AUG 1 9 2000 Registrar **DHMH 16 Rev 6/95**

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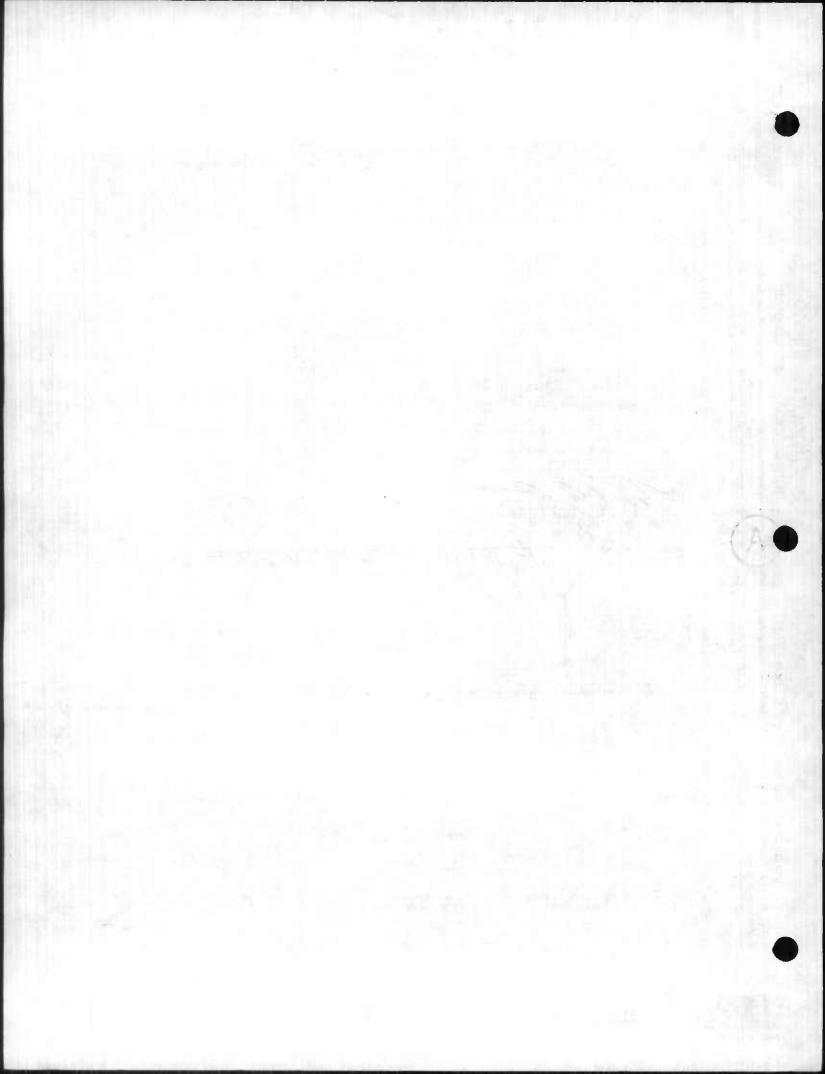
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State of Maryland / Department of Health and Mental Hygiene Amended items# 1&23 per ME G786 8-21-00 WJJ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Deeth Charleen M. Cross 235 **Physician** HUGUST Charlene 9,2000 M Cross /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end pumber) 4c. County of Death Examiner Baltimore City Hospital Maryland General NA 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. Birthplace (Stete or Foreign Country)
 NC 7. Age (In yrs. last birthday) **Funeral** Days Min. Hours 1□ M 2☑ F Yrs. 59 Director 238-62-8346 08-20-40 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits Yes 2□ No 28a-1 Directo MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Harne 23s 1718 N. Bond Street 21213 Funeral USA 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 Yes SANO If Yes, Give Year or Detes: 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Reistered Nurses Private Duty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) ould be Mental Charles Keck Katie Haywood 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Neme/Relationship (Type, Print) Allan Cross Hem 27 1718 N. Bond Street Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X ⊠ Burial 2 ☐ Cremetion 3 ☐ Removal from State Garrison Forest VA Cem. 08-16-2000 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 000 Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 200 natical used the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, and line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death or comoli Arterial Respiratory Distress Syndone Paisic an /N.edipal Immediate Ceuse (Final diseese or condition resulting in death) (UI TURE Eys...iner Dun to for as a consequence of) Physician/Medical Examine The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of): Box (P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by Division of Vitai Records. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes AZ No 1- Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier completaly 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 764-1 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 40 Rhoades Jary 32. Registrar's Signeture 31 Date filed (Month, Dey, Year) State AUG 2 1 2000 Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

26327 MICLICK CHURCHILL Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Miclick Churchill 2000 0603 AM AUG. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 11-17-97 5 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min XXM 2DF Yrs. 2 Ilnknown MD Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsma 23a or 26a-l show the Medical Examiner must be notified at M3Yas 2□No MD NA Baltimore Directo 94 10f. Zip Code 10g. Citizen of What Country? 10e. Sfreef and Number 21215 USA 2623 Park Heights Terrance Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 24 ☐ No If Yes, Giva Year or Dates: Never Married 2☐ Married Maryland 21215-0020 1 Yes 25 No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry filed within Elamentary/Secondary (0-12) College (1-4or 5+) Child Child Child Child Hygi 18. Mother's Name (First, Middle, Maidan Sumeme) 17. Fathar's Name (First, Middle, Last) Department of Yealth and Mental I Important! If Item 27 is merited of any Injury or other traumers. Michael Churchill Cindy Hitchcock 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21217 19a. Informant's Name/Ralationship (Type, Print) Patricia Jackson 1214 McCulloh Street Baltimore, Maryland Baltimore, 20b. Place of Disposition (Neme of cemetary, crametory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State King Mem.Pk. Cem. 08-10-2000 Randallstown, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Baltimore, Maryland 21202 eman Bron WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one causa on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yas 2 No 3 Probably 4 Unknown by 24b. Wars autopsy tindings available prior to complation of causa ot death? 24a. Was an autopsy performed? Completed peen page 2 certificate has 1 ☐ Yes 2 ☐ No Physician: 25. Was case raterrad to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) P P Yes 2□ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this eral Director: After this filled in by the funeral Date of Insury (Month/Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury, occurred 28c. Injury at Work? Certification: or Attending 5 Pending investigation Injury 1 Natural UNK てか death. 1 Yes 00 oused 100 25 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town Stete) 3 ☐ Suicide 28a! Place of Injury - At home, farm, street, factory, office building, atc. (Specify) aftar 4 Homicide 623 Home 73 within 24 hours of 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier pletely one) the the 29d. Date signed (Month, Day, Year) 29b. Signalii 29c. License number AUG. 7, 2000 O.C.M.E

State Registrar

31. Date filed (Month, Dey, Year) AUG 21

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(my) 32. Registrar's Signatura

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

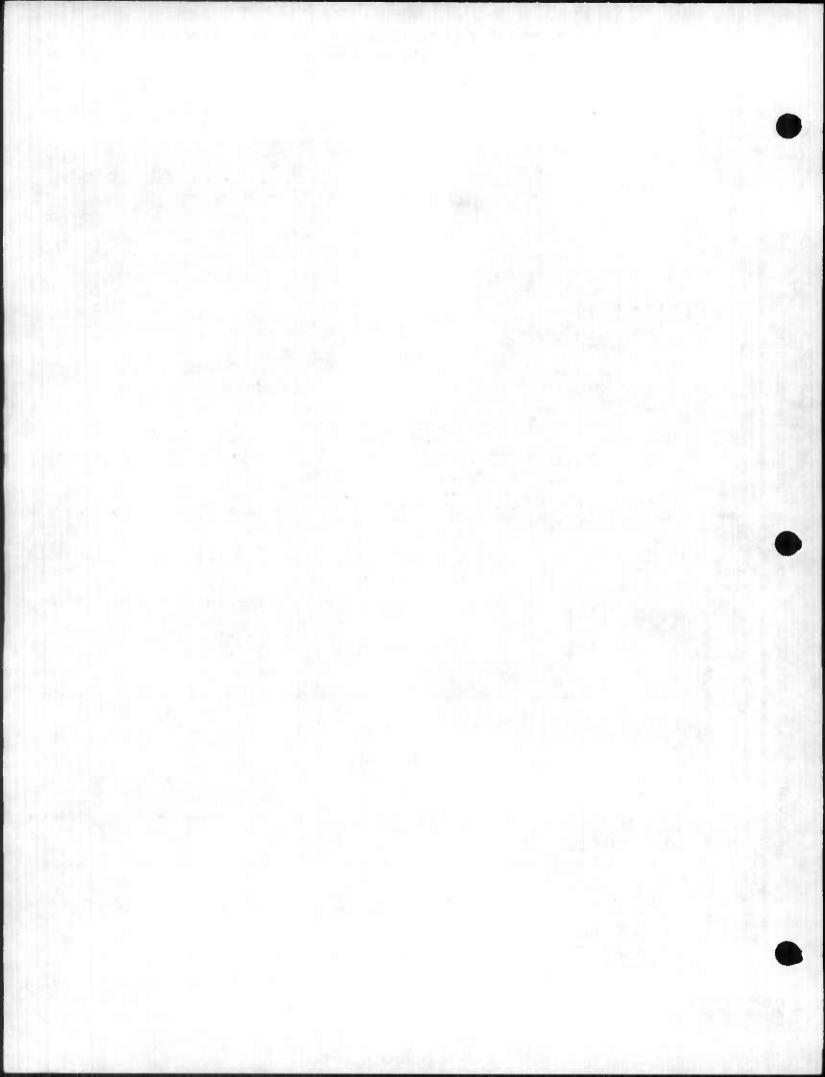
111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 00 26328

			Certificate of	f Death	Reg	. No.	20020						
1.4.	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Ye	3. Time of Death						
Physician /Medical	Janis G. Coste	11		0.00		17, 200							
Examiner	4a Facility Name (If not institution, give street	et and number)		4b. City, Town, or Lo	cation of Deeth	4c. County of D							
	Gilchrist Center			Towson	100	Balti	imore						
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Yes		8. Dete of Birth (Month, Day, Y	9.	Birthplaca (State or Foreign Country)						
Director	215-62-6554 1DM	20 F 48	Yrs. Months Day	s Hours Min.	Nov. 10,	1951 N	Maryland						
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te to	Maryland Howard	CO.	lumbia				1 ☐ Yes 2X No						
or 28s-fr	10e. Street and Number		10f. Zip Code		100	. Citizen of Wha	t Country?						
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iner m		Wes Decedent Ever in U,S. Armed Forces?	If Yes, specify Cu	Hispanic Origin? (Spetban, Mexican, Puerto	Rican, etc.)		White, etc.						
by F	-8	Yes 2000 Yes, Give	1□ Yes 2XN	o Specify:		Specify:	white						
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edical	15. Decedent's Education (Specify only highest grade continuous)		Decedent's Usuel Occ (Give kind of work don	e during most of worki	ng 16	b. Kind of Busin	ess/Industry						
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0	Joseph Goodwin			virgini	a Hawkins	5							
	19a. Informant's Name/Relationship (Type,	Print) 19b	. Mailing Address (Stre	et end Number or Rurs	al Route Number, C	City or Town, Ste	ite, Zip Code)						
	Tom Costell / spous	se 86	698 Open Me	adow Way	Columbia.	, MD. 2	21045						
6	20a. Method of Disposition	cemete	Disposition (Name of ry, crematory or other p	laca)		c. Location - Cit	y or Town, State						
7 0 1	1 ☐ Burial 2 【XCremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from Stale Metro	Crematory	A	ug. 21	atonsvil	lle, Maryland						
7	21. Signeture of Funeral Service Licensee	M01044	22. Name and Add		2000		7						
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TOTAL .	Show a Col	lino- Willyt	4112 010	Columbia P	ike Ellic	ott Cit	v MD 21043						
	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications of the complex of the com	ons thet caused the death. Do i	not enter the mode of d	ying, such as cardiac o	or respiratory arrest		Approximate Interval Between						
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detached for us	Pert II. Other significant conditions contribu	iting to death but not resulting if	n the underlying cause	given in Pert I.		1	buts to the causs of death?						
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pleted							of death?						
E					1 ☐ Yes	2.XV0	1 ☐ Yes 2 ☐ No						
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- O	axaminer?	itel: 1 npatient 2 ER/Ou	stpatient 3 DOA	Whar-	me 5 Residence	ca 6 Other	(Specify) HOSAIC						
	27. Manner of Death 2	Ba. Date of Injury 28b.	Time of 28c. In		28d. Describe how								
fun tor		(Month, Dey Year)		ork? ☐ Yes 2 ☐ No									
by me	3 Suicide 6 Could not be	Be. Piece of Injury - At home, fa	orm street factory offic	9	28f. Location (Stre	et and Number	or Rural Route Number,						
Certification:	4 Homicide determined	building, etc. (Specify)	ini, sileet, lactory, onic		City or Town,	Stete)							
edical	(Check only 2 Medical Examiner:	 To the best of my knowledge On the basis of examination an 											
		and manner stated.											
Σ	29b. Signature and title of bertiller	110	0	nse number	1	1	Month, Day, Year)						
	e moun	1 /liley (of	N 1)2	25205	4	199115	1 18, 2000						
1	30. Name and address of person who consult	wheel cause of deaty (Item 23a)	(Type, Print)			1	Md 2120						
-	1) An led	GBACC 6	701 NG	Charles	St. 8	alto.	Mg 5129						
Chata	31. Date filed (Month, Day, Year)	2 Registrar's Signature											
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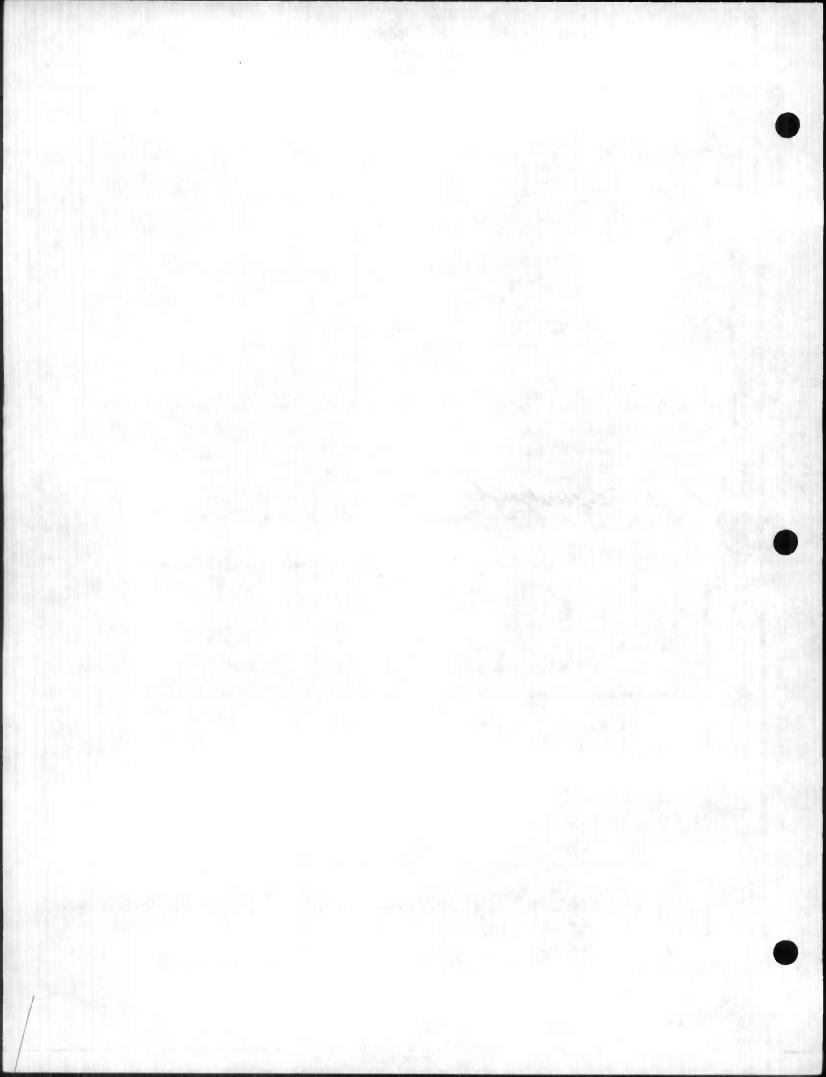
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State of Maryland / Department of Health and Mental Hygiene 00 26329

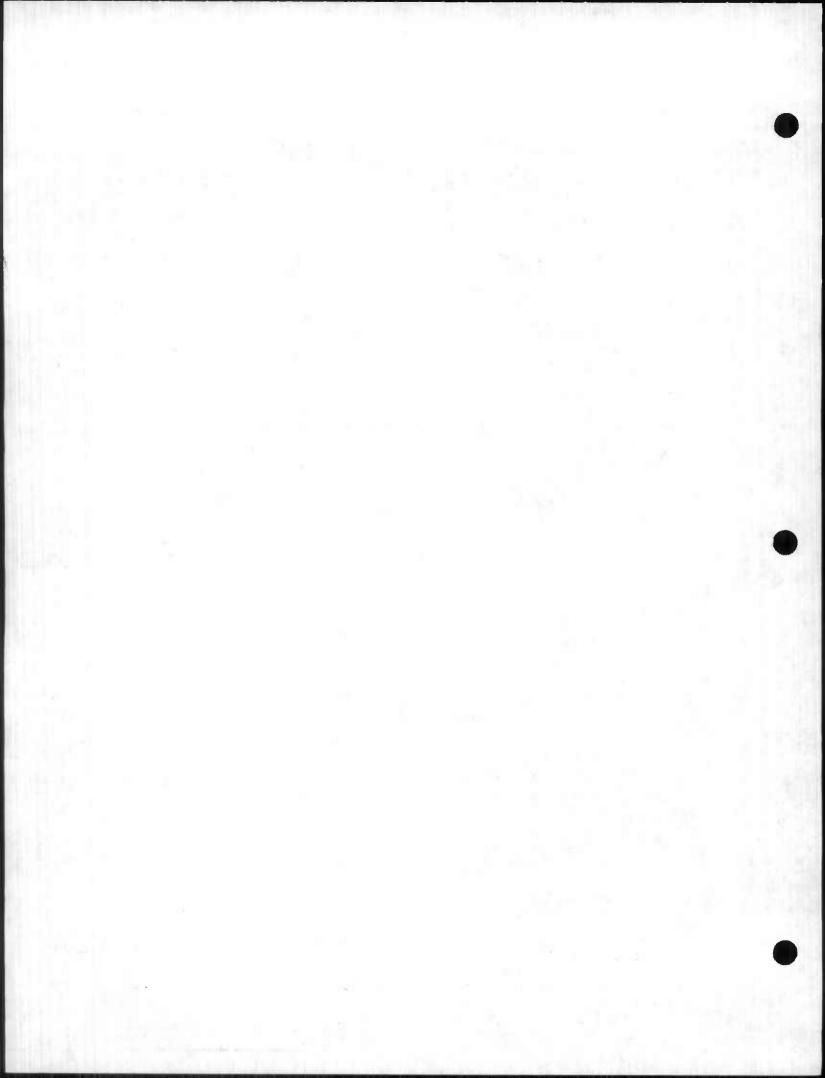
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		1. Decedent's Name (First, Midd	lle, Last)						11.02	2. Date of Month	Death Day	y Yeer	3. Time of Death
Physi		Martin Jo	hn (Chris	t							19,20	00 2:20pm
/Med Exam		4a Facility Name (If not institution	on, give s	treet end nu	nber)			4	4b. City, Town, o	r Location of De		County of Dea	
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⁹ Funer	s1	5. Social Security Number	6. Sex		7. Age (In yrs.	. last birtho		der 1 Year	If Under 24 H		Birth .		thplace (Stete or Foreign ountry)
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A Mand		10a. State 10b. County	/		10c. Ci	ity, Town o	r Location		7-7-				10d. Inside City Limits
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0020 hours after turnit, or the	by F	1 Never Merried 2 Mai		1 Yes If Yes, Giv	e X No	204	1 ☐ Yes	2 No	Specify:			Specify: W	hite
21215-0020 dwithin 72 hours affords.		3 Widowed 4 □ Divorce		Yeer or D	ates:								*****
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5 5 5 7 7		Linda Adamcz	yk(c	daugh	ter)	10)5 S.	Stu	art St	reet B	alto	., Mary	land 2122
Ore Head Head		20a. Method of Disposition			20b. I	Place of D	isposition (A	Vame of	nel.	Date	20c. Lo	ocation - City or	Town, State
timore, M timore, M Pages 1 and 2 ment of Health 1		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		moval from	State Bel	Air	Mem	oria	ľ	8/22/0	0 Be	l Air,	Maryland
Baltimore Santimore Pages 1 s Pages		21. Signature of Funeral Service			1		22. Name	and Addre	ss of Facility D		l- i	Dinner	al Home P
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	/	June 1	7	/								Ito., M	d. 21221
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ZXXIIII		resulting in death)					nsequence o						
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and and	Carr	Sequentially list conditions,		1.15	Dua to (or as a cor	nsequence o	of):			0		
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ds, Fires that signed to ded to det	N Y	0/12	21	ROT	-6								
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Cord w require been si	ete	VS.	rey	bera	2 ()6	escu	las	1k	sear.	_ P	rformed?		completion of cause of death?
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E Page	ပိ											Ø No	1 ☐ Yes 2 Ø No
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ng P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pandi	ing	28a. Date (Mon	of Injury th, Day Year)	28b. Tim	iry	28c. Injur Wor		28d. Descri	e how inju	ry occurred	
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Visit Am	THE STATE OF	3 Sulcide 6 Could 4 Homicide	nined	28e. Place buildi	of Injury - At h	nome, larm	, street, fact	tory, office		26f. Locatio	n (Street er Town, State	nd Number or F a)	Rurel Route Number,
O SECTO	Ç												
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Division of To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medicai Certification:	(Check only 2 Medica	agimin		asis of examine ner stated.	etion end/o	л investigati	on, in my o	pinion, death oc	curred at the tin	ie, uatė and	o piace, and di	ue to the cause(s)
ro th	Σ	29b. Signature and title of partis	01/	111	1		2	29c. Licens	se number		29d. Da	te signed (Mor	nth, Day, Year)
		11/	6 1	10)	mr		Di	1012			4/2	1100
12	/	30. Nama and address of parsor	who or	nnleted cause	a of death (It-	m 22a) (T	me Print)	V	1-10			0/-1	1
10									1	3.00	120/		
		Dale Buchbinde 31. Dete filed (Month, Day, Year			569 N. egistrar's Sign		res St	., Ba	altimore	2, MD 2	1204		
S Posis	itate	ALIC 2 1 2000	h	enever	19	10	ands						



	1 Secreta Nama (Cine) Middle La	State of Maryland /		te of Death		Reg. No.	26330
Physician /Medical Examiner	HYDES E	Corbin		12.11	Month AUGUST T Location of Death	Day 14 2	Year 2000 1:0
Funeral Director	5. Social Security Number 6. S	ax 7. Aga (In yrs. last b	Yrs. If Under	er 1 Yaar If Undar 24 Ĥ	rs. 8. Data of Birth	7. Year) 2	9. Birthplace (Stata or Country)
with the Maryland a or 28s-f show the notified	10a. Stata 10b. County	1 10c. City To	wn or Location			10-01-1	10d. Insida City
iffer death with the Ma if thems 23s or 28s-f s inc. must be nouth	2822 Belm	nont Ave	101. 2	21216		10g. Citizen of V	3. A
or and year	3 Widowed 4 □ Divorced	12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ HO If Yas, Giva Yaar or Datas:	13. Was Dec	edent of Hispanic Origin? ecify Cuban, Maxican, Pur 2DNo Specify:	(Specify Yas or No- arto Rican, atc.)	14. Rac Blac Specify	e - Amarican Indien, ck, White, atc.
led within 72 hours after bygiene. Ser than "natural", or to to to the first by the district by First	15. Decedant's Ed (Specify only highast gra		a. Decedant's Us (Giva kind of w life. DO NOT	ork dona during most of w	vorking	16b. Kind of Bu	usinass/Industry
Mental H Mental H mrked out	17. Farners Name (First, Middle, Last)	cc			ama (First, Middle,	Maidan Sumam)
iges 1 and 2 sh of Health and if frem 27 is m or other traum	19a. Informant's Name/Relationship (19a. Informant's Name/Relationship (19a. Information 19a. Information 19	Brown - Daughter - 20b. Place ceman	9892 of Disposition (No ery, cremetory or	BC I MONT ama of other place)	Ave . Polite Date	altimo	. M/
permit. Pa Departmen Important any injury phos.	21. Signature of Funeral Service Lices	1 10000	22. Nama a	1. 11.	opolitan	Chape	1 P.C. 13
Physician /Medical xaminer	Immediata Causa (Final disaasa or condition rasulting in daath) Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury	b	consequence of		enlar l	Ireise	year
oding physiciar use as the buri	rasulting in death) Last	C. Due to (or as a	consequanca of	:			
ed by the attending detached for use an	Part II. Other eignificant conditions of	7 '				obacco uee co	ntribute to the cause of
ate has been signe page 2 should be d		Anema Cirhosis			24a. Was perlo	an autopsy rmed?	24b. Wara autopsy fin availebla prior to complation of ca of death?
		Circhoses			101	as 2000	1 □ Yas 22 N
After this certific thanks director	1 Yas 2 No	(Month, Day Year)	Outpatient 3 C Tima of Injury	Other	Heath (Check only on Home 5 Residue) 28d. Describe h		
na after death. al Director: After led in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not be datarmined	28a. Placa of Injury - At homa, building, etc. (Specify)	farm, streat, facto	ry, offica	28f. Location (S City or Tow	Straat and Numb m, Stata)	per or Rural Routa Numb
Puner Funer files ill		yelclan: To the best of my knowledg liner: On the basis of axaminetion a and mannar stated.					
within to the To the Member	29b. Signature and title of certifier	Synno		38543			d (Month, Day, Year)
No		completed cause of death (Item 23a ULL 668 WW.) 900	(Type, Print) Catun/	Nonne Bal	Homore, "	ulany lu	wl 21219
State Registrar	31. Date filed (Month, Day, Year) AUG 1 9 200	32. Registrar's Signatura	B A.	an Ka			

DHMH 16 Rev 6/95

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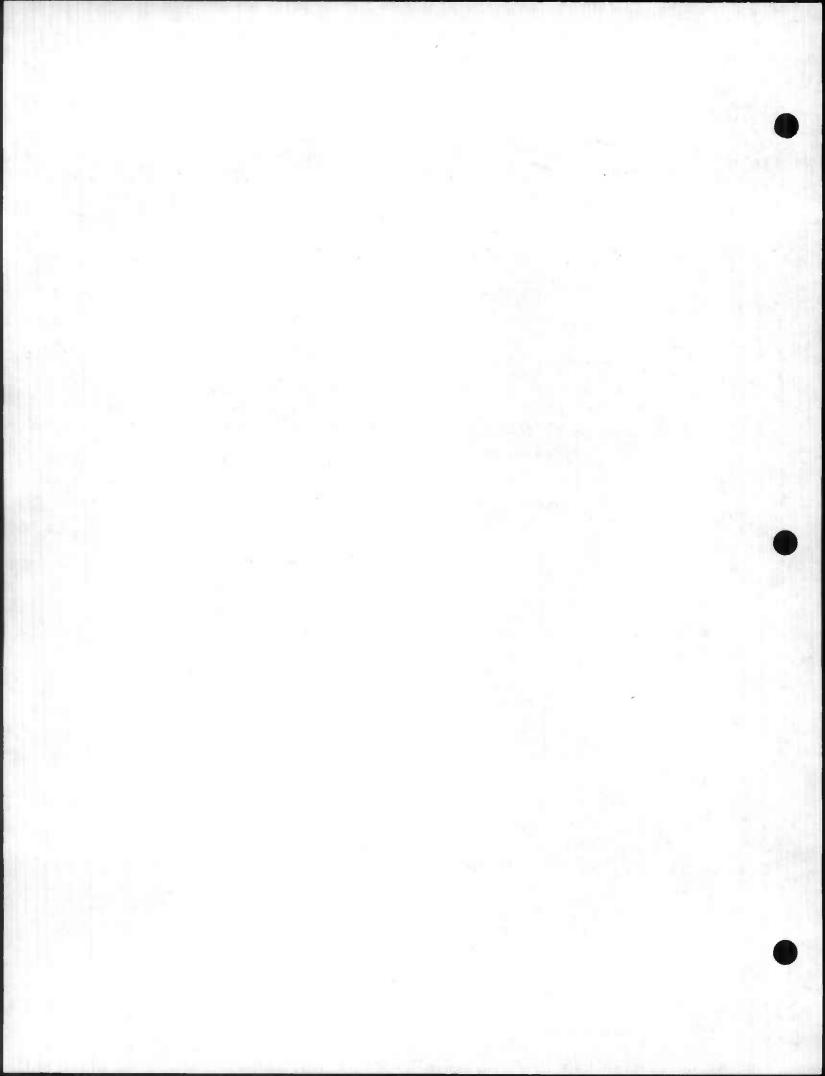


DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

nysician Medical xaminer	4 Decadente Name /First Middle 1		001111001	e of Death	PI	eg. No.	
Medical	Decedent's Name (First, Middle, L.	ast)			2. Dete of Deat Month	h Day Year	3. Time of Death
	Wilmer L). 1)4/1a			AUGUST	16, 2000	
	4a Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Death	4c. County of Dea	ath
	UNION MEMORIAI	HOSPITAL		BALTIN	ORE CITY	1	1/A
ral tor	5. Sociel Security Number 6. 2/9 - 38-378/	Sex 7. Age (In yrs. 12M 2DF 57	last birthday) If Unde Months	r 1 Year If Under 24 H Days Hours M	In. 8. Date of Birth Month, Dey,	Year) 9. By	Inplace (State or Foreign Country)
	Usual Residence of Decedent	110-01	Town or Location		1000-11		10d beide Challette
ral Director	10a. State 10b. County	A 10c. CR	Baltin	IRE	12-13		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
I Director	10e. Street and Number 3/9 LOCKO	ine due		2/2//	1	Og. Citizen of What C	
by Funeral	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 NO If Yes, Give Year or Dates:	If Yes, spe	dent of Hispanic Origin? cify Cuben, Mexican, Pu 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:	
	15. Decedent's I	Education	16a. Decedent's Usu	al Occupation	unrtino	16b. Kind of Busines	
Completed	(Specify only highest g	College (1-4or 5+)		ork done during most of ise retired) MAKER	WORKING	Facto	Ry - PHAL
Be C	17. Father's Name (First, Middle, Las	1) . (18. Mother's I	Name (First, Middle, I		
ToB	GILBERT DE	lla		Ma	RGARET	- Bass	dalE
	19a. Informant's Neme/Reletionship	(Type, Print) (SISTER	19b. Meiling Addres	s (Street end Number or	Rurel Route Number	City or Town, State,	
	20a. Method of Disposition	JUNE 20b. F	Place of Disposition (Ne	me of	Date	20c. Location - City o	7. 2/229 or Town, Steta
	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, crematory or	other place)	8/23/2000	P. Harm	· md.
4	21. Signettife of Funeral Service Lio	National Control	22. Name a	nd Address of Facility	Ben	5 FUNER	to House
9	Dan 101	1 60	117.5		1.	BIL	a weld 20
	23a. Pari 1. Enter the disease, or conspect, or heart failure. List only	mplications that caused the deet		M - Caco de of dying, such es care	***	est,	Approximate Interval Between
ner	Immediate Cause (Final disease or condition resulting in death)	a. Arterioscle	rotic Cardi or as e consequence of	-)isease		
el Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequence of)				
for use as the buriel-transit clan/Medical Examir	that initiated events resulting in death) Lest	Due to (d	r as a consequence of)				
/ Physician/	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	ceuse given in Pert I.	23b. Did to	obecco use contribu	te to the cause of death?
Phys					1 🗆 Y	88 2 No 3	Probably 4 Unknown
Completed by					24e. Was a perform		Were sutopsy findings available prior to completion of cause of death?
mo					1 U Y	-	1 ☐ Yes 2 ☐ No
9	25. Was case referred to medical			26. Plece of	Deeth (Check only on	10)	
То Ве Сотр	exeminer? 1 X Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient X D	OA Other: 4 Nursin	g Home 5 Reside	ence 6 Other (Sp	pecify)
tlon:	27. Menner of Death 1 Neturel 5 Pending 2 Accident investigeti	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
Certification:	3 Suicide 6 Could not determine	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ry, office	28f. Location (St City or Town	treet and Number or in, State)	Rural Route Number,
edical C		hysician: To the best of my knominer: On the basis of examina and manner stated.					
4	29b. Signature and title of certifier		29	c. License number	2	9d. Date signed (Mo	nth, Day, Year)
2	11/1	Lano		OCME		AUGUST 17	, 2000
2	V/1.	-					
completely filled in by the funeral Medical Certification:	30. Name and address of person who	completed dadse of death (Iter		Street, Bal			201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Michael Thomas Duncan 17 2000 10:25 am August /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA Medical Center, Fort Howard, Maryland Baltimore Fort Howard 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fo Country)
Aug. 20 1938 South Dakota 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 61 479-38-2364 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Manylai Department of Haalih and Menial Hydiene. Important: If Itam 27 is marked other than "natural", or harms 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified anones. 1 Yes 2 □ No Director Iowa Sioux City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2115 Summit Street Funeral 51104 U.S. of America 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Merried White Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Music Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald Duncan Dorothy Kellv 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Summit Street Siox, Iowa 51104
ce of Disposition (Name of Date 20c. Locatio Virginia Duncan (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 1 ☐ Burial 2XI Cremation 3 ☐ Removel from State Metro 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21 22. Name and Address of Facility
W. Dabrowski-Chojnacki F.H. 's P.A. 1005 Dundalk Ave. Baltimore, Md. 21224 23a. Part1. Error the disease, or complications the shock, of heart failure. List only one cause or the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Malignant Melanoma with Metastasis 3 months Examiner Due to (or as a consequence of): Physician/Medical Examine attending physician and for use as the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 to Yes 2□ No 1 ☐ Yes 200No of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division XXVatural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide To the Hospital or Alla within 24 hours effected To the Funeral Directo completely filled in by it 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14958 August 17, 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Aurora C. Tan, M.D. 9600 North Point, Road, Fort, Howard, Maryland 21052

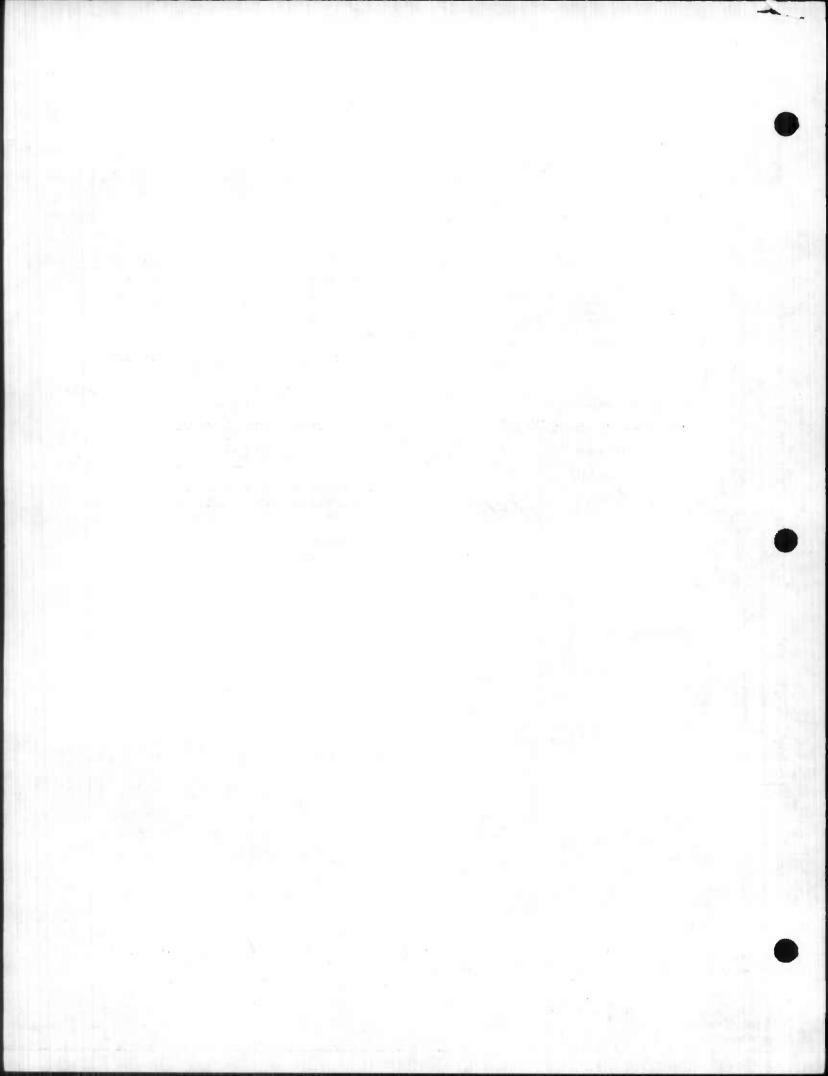
DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month Gay Year) 2000

AKA: Duncan, Michael

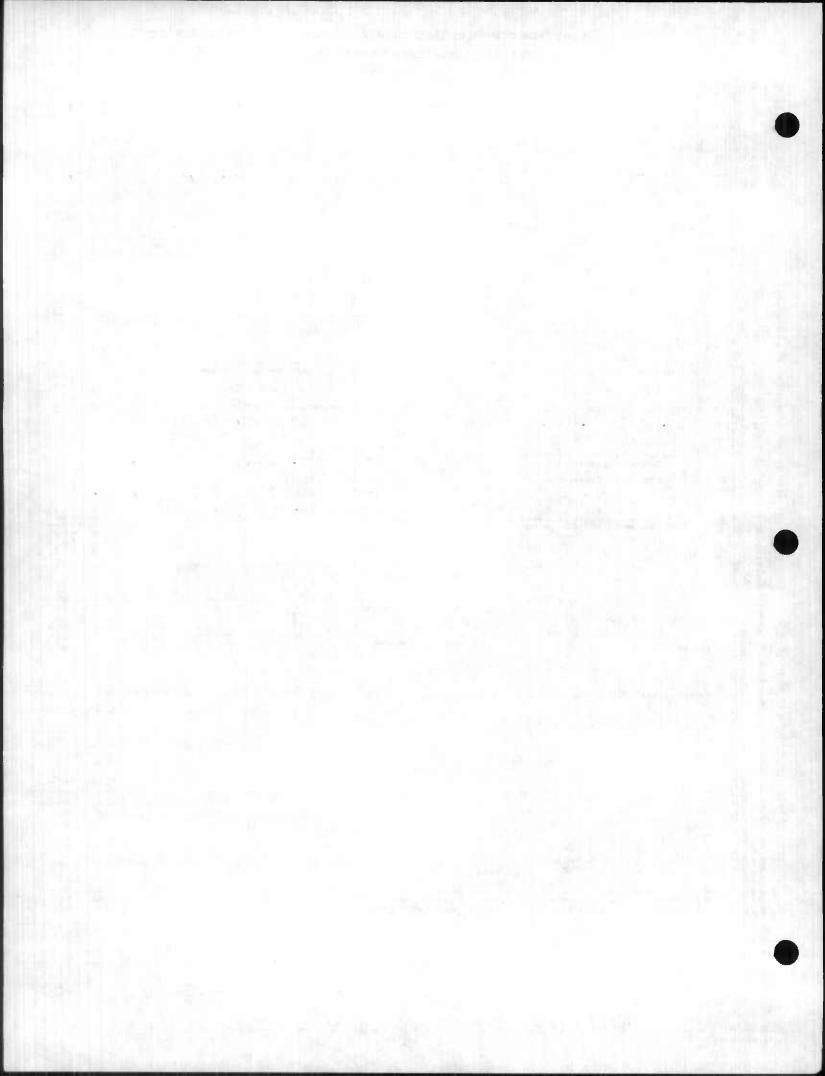
32. Registrar's Dignature



State of Maryland / Department of Health and Mental Hygiene 00 26333

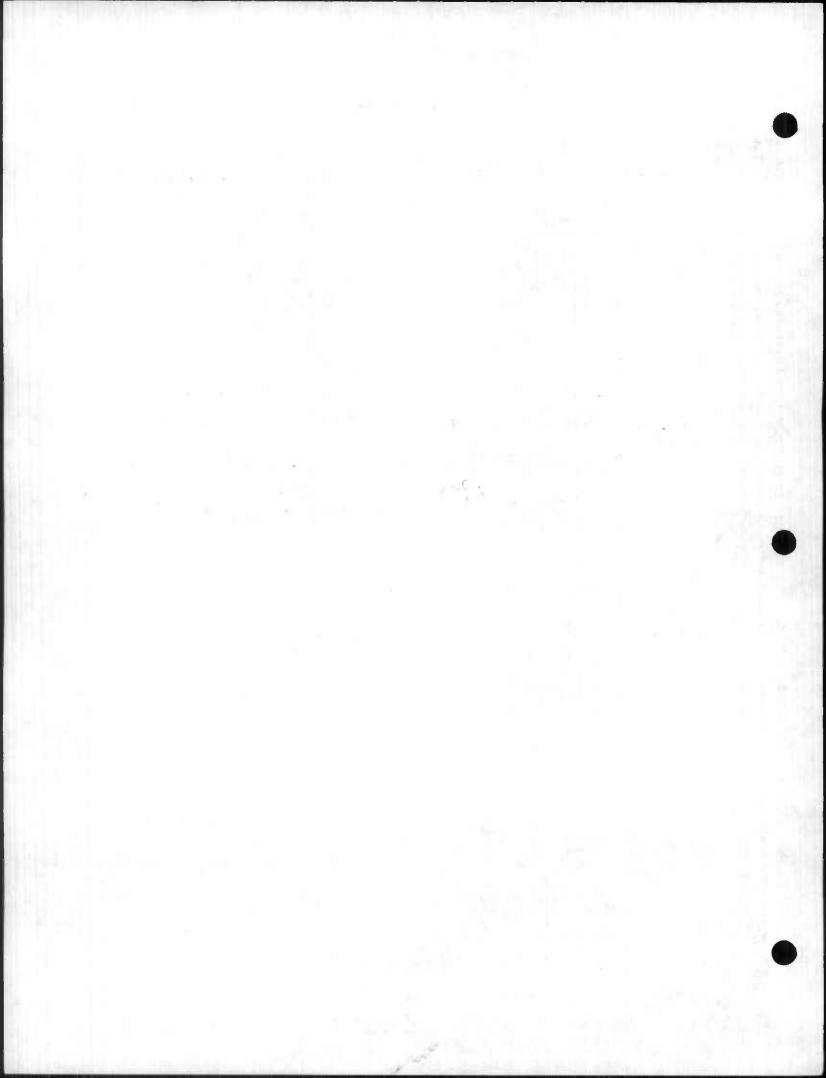
	Certificate of Death	Reg. No.	20000			
Dhusisian	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Ye	3. Tima of Death			
Physician /Medical	Racilleen Naimecc Davies	August 17, 2	2000 11:25 AM			
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Tow 68 Shore Road Edgem	m, or Location of Death 4c. County of I	Death :imore			
	5. Social Security Number 6. Sex 7. Age (In y.rs. lest birthday) If Under 1 Year If Under 2					
Funeral Director	217-24-4777 1□ M 2⋈ F 72 Yrs. Months Days Hours Usual Residence of Decedent	Min. (Month, Day, Year)	Birthplace (State or Foreign Country) Edgemere, MD			
M M	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits			
ar death with the Maryla heres 23a or 25a-f sho net must be notified at unearal Director	Maryland Baltimore Edgem	ere	1 ☐ Yes 🏖 🖾 No			
or 28e-f a	10e. Street and Number 10f. Zip Code	10g. Citizen of Wha				
23a Mart 3						
	11 V 0'- 1 1 V 00' N - 0 16.	in? (Specify Yes or No- Puerto Rican, etc.) 14. Raca - Black, \(Specify: \)	American Indian, White, etc. White			
21215-0020 d within 72 hours at green, a return "neturns", or then "neturns", or the Medical Exam compileted by 8	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	of working	ness/Industry			
21215-0 ad within 72 ho ygiens, we than 'natur it, the Medical.	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)					
Con the state of t		Hosp				
Maryland 42 should be flish and Mental Hyb 7 is marked oths traumatic event	17. Fether's Name (First, Middle, Last) Adrian Frances	r's Name (<i>First, Middle, Maid</i> en <i>Sum</i> eme) Margaret Murphy				
The state of the s		umber or Rural Route Number, City or Town, Stata, Zip Code)				
Manual Supering Manual Superin	Mr. Gwilym A. Davies (Husband) 68 Shore Road Edg		21219			
	20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place)	Date 20c. Location - Cit	ty or Town, State			
Page ont iff	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp.	8/21/2000 Towson,	Maryland			
altimore mit. Pages 1. partment of Hs portant; if her r fejury or oth	21. Samure of Funeral Service Licensee 22. Name and Address of Facility					
m sees		al Home of Dundalk, Dundalk, Maryland	Inc. 21222			
	2. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	ardiac or respiratory errest,	Approximata Interval Between			
Physician /Medical	Immediate Cause (Final disease or condition Westas Fafic Breast Carry		Onset and Death			
Examiner	resulting in death)	er	2 myrs			
خ المسلس	Due to (or as a consequenca of):					
58760, crate be assected physician and s the bunal-transit	Sequentially list conditions, Due to (or es a consequenca of):					
68760, tificate be assect g physician and as the buriat-tre						
68760, ificate be aw g physician as the bunal	that initiated evants resulting in death) Last Due to (or as a consequence of):					
5 pa						
O. BOX o death cent the attendin hed for use		L col. Dida.	1			
P.O. BOX lat the death cert d by the attendin etached for use	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contri	Dute to the cause of deeth?			
	menytate eleval involvement					
Vital Records, P.O. Box idian: The law requires that the death cercertificate has been signed by the attendinicator, page 2 should be detached for use Be Completed by PhysicianA	malione of Plance & Edducion	24a. Was an autopsy performad?	24b. Ware eutopsy findings evailable prior to			
0 2 20 0	A STATE OF THE STA		completion of cause of death?			
The The Page	0	1 ☐ Yes 2 ₺No	1 ☐ Yes 2 ☑ No			
f Vital Reyriclan: The lay yaiclan: The lay director, page 2		of Death (Check only ona)				
Physic this care direction of T.	To inpatient 20 Envoypatient 30 DOA 40 Nut	sing Home 5 Presidence 6 Other (28d. Describe how injury occurred				
ding ding After fune	27. Manner of Death 28a. Data of Injury 28b. Time of 12hours 15 Pending (Month, Dey Year) 28b. Time of 12hours 15 Pending (Month, Dey Year) 12hours 15 Pending 15 Pen					
Division of Vita no the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be	2 Accident investigation 3 Suicide 4 Homicide Could not be datarmined building, etc. (Specify)	28f. Location (Street end Number City or Town, Stete)	or Rural Route Number,			
Cer illed in						
To the Hospita within 24 hours To the Funeral completely filled	29a. Certifier (Check only (Check only one) 1 Certifying Phyeician: To the best of my knowledga, death occurred at the time, date and (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deatled.					
official of the office of the	29b. Signature and title of cartifler 29c. License number	29d. Date signed (/	Month, Dey, Year)			
F3F8	1 / my 8 5/ M.D. 75491	11 08-1-	7-00			
with						
No.	Korristo B. Erlich - 4940 Flastern Ave A.	Building My 112 BAHi	imore MD 2122			
State	21 Date filed (Month Day Year) 22 Besistands Signature					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 26334

			Ce	rtificate	e of I	Death		Re	g. No.		
	1. Decedent's Name (First, Middle, Las		-1.11				2. Dete of Death Month Day Yee			3. Tima of Death	
nysician Medical		Alfred Ar	nthony I	el Ci	ello)		AUGUST	16,200	00	11:05 P
kaminer	4a Facility Neme (If not institution, give	street and number)		-	4	b. City, To	wn, or Loc	ation of Death	4c. County	of Death	
	JOHNS HOPKINS	BAYVIEW				BALT	CIMOR	E		N/A	
i	5. Social Security Number 6. Se		n yrs. last birthday) If Under Months	1 Yeer Deys	If Under	24 Hrs. Min.	8. Dete of Birth (Month, Day,	Veer)	9. Birth	plece (Stete or Foreig
	214-20-4/11	2 F 70	Yrs.	MORITIS	Deys	Hours		Dec. 20			yland
	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation							10d. Inside City Limits
ctor		imore				Dur	ndalk				1 ☐ Yes 2 ☒ No
I Director	10e. Street and Number 8191 Mid Haven F	Road		10f. Zip	Code	2122	22	10	og. Citizen of the United		
Funeral	11. Merital Status	12. Was Decedent Eve	r in U,S. 13.	Was Deced	dent of H	ispanic Ori	gin? (Spe	cify Yes or No-	14. Rac	ce - Americ	can Indian,
F	1 Never Merried 2 Married	Armed Forces? 1 □XYes 2 □ No					n, Puerto F	Rican, etc.)	Bla	ck, White,	etc.
þ	3√ Widowed 4 Divorced	If Yes, Give Yeer or Dates: Ko	rean	1 ☐ Yes 2	20 No	Specify:			Specif	y: Wh	ite
	15. Decedent's Ed	ucation	16a, Dece	edent's Usua	1 Occup	atlon	4 - 4 4 !-		6b. Kind of B	usiness/In	dustry
Completed	(Specify only highest grade Elementery/Secondary (0-12)	de completed) College (1-4or 5+)	(Giv	DO NOT us	rk done i se retired	dunng mosi d)	t of workin	19			
Eo	6 Years	College (1-401 3+)		Tile S	ette	er			Ur	nion	
Bec	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle, M	feiden Sumar	ne)	
To B	Alfred A. Del C	Ciello						Rose M	. Во	rrel	li
-	19a. Informant's Name/Relationship (7		19b. Mei	ling Address	(Street	end Numbe	er or Rura	Route Number,			
	Mrs. Susan Saveres			-				ndalk,		_	21222
	20a. Method of Disposition		20b. Place of Disp	osition (Nen	ne of			Date 2	Oc. Location	- City or To	own, State
	1 ☐ Burlel 2 ☐ Cremation 3 ☐		cemetery, cre				0/10	12000	Merico	n M-	werland
	4 □ Donetion 5 □ Other (Specify 21. Signature of Funeral Service Licen		Hilltop					72000	TOWSO	II, Mc	ryland
	21. Signature of Funeral Service Licen	see		2. Name en Duda-				Home of	Dunda	lk. T	nc.
	23a. Part1. Fill if the disease, or compared to the street of the street	(and		7922	Wise	a Ave.	- Du	ndalk.	Marvla		
edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease of Injury	b. ATHEROS	yocardia e to (or as a conse CLERNIC e to (or as e conse	equence of):			R I	DISEASE			
Medical	Cause (Disease or Injury that initiated events resulting in death) Last	c	e to (or as e conse	quence of):							
SICE	Part II. Other significant conditions of	ontributing to deeth but n	ot resulting in the	underlying c	ause giv	en in Pert I	l.	23b. Did to	bacco usa co	ontributs t	to the cause of death
Phys								1 🗆 Yı	8 2□ No	3 Pro	bably 4X Unknow
by											face and a second
Completed by Physician/						Bar		24a. Was an perform INSPE	n autopsy ned? CTION	CI	Vere autopsy findings vailable prior to ompletion of cause I death?
THE C								1 TI V	s 2 No		☐ Yes 2√2 No
Ö	Of Management to medical										Yes 2 No
Be	25. Was case referred to medical axaminer?	Hospital:	100		Oth	or:		(Check only on			
on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Dete of Injury (Month, Day Y	28b. Time injury		28c. Injur Wor	40146	-	ne 5 Reside 28d. Describe ho			ify)
atic	2 ☐ Accident Investigation			M		Yes 2	No				
BLUIC	3 Suicide 6 Could not be 4 Homlcide determined	28e. Place of Injury building, etc. (- At home, farm, s Specify)	treet, factory	y, office		2	28f. Location (St. City or Town	reet and Num , Stete)	ber or Rui	rai Route Number,
Medical Certification:		yelclan: To the best of n									
Pe	one)	and manner states	1)								
2	29b. Signature and title of certifier	1 /~		290		e number		2	9d. Date sign		
			Mil		0.	C.M.E	1 0		AUGUS	ot T\	, 2000
	30. Name and address I person who d	completed cause of leat	h (Item 23a) (Type	, Print)							
	MARY RIPPLE M.D		Street,		imor	e, Ma	ry]a	nd 21201			
State	31. Date filed (Month, Day, Year)	32. Registrar's									
trar	Atus 2. 1 700	111 Dener	4.1	19/1	in V	_					



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible 6 3 3 5
State of Maryland / Department of Health and Mental Hygiene

		cate of Death	Reg. No.	10=-40-4
Physician	1. Decedent's Name (First, Middle, Last) LOIS DAVIS		2. Date of Death Month Day	Year
/Medical	4a Facility Name (If not institution, give street end number)	4b. City, Town, or Loc	August 17,	2000 10:05am
Examiner	Sinai Hospital of Baltimore	Baltimor		NA
Funeral	5. Social Security Number 6. Sax 7. Age (In yrs. last birthday)	II do a War I WILL do a CALLE T	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
rector	214-78-2179 15m 29 Vis.		Aug. 20, 1960	Maryland
-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Localic	n	•	10d. Inside City Limits
oto in	md. Bactimore Ka	ndallsTow	n	1 □ Yes 2000
Director	3711 Mc Dunogh Road	01. Zip Code 2 / / 3 3	10g. Citizen of	What Country?
Funeral			cify Yes or No-	ace - American Indian,
Fun	1 Mayor Marriad 2 Marriad 1 Vac 2 Miles	Decedent of Hispanic Origin? (Spec s, specify Cuban, Mexican, Puerto R	lican, etc.) Bi	ack, White, etc.
by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dales:	res 2 Dino Specify:	Spec	ily: Black
Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind	S Usual Occupation of work done during most of working OT use retirant	16b. Kind of	Business/Industry
dm	Elementery/Secondary (0-12) College (1-40r 5+)	D = =====	Res	turants
	12-th 2 years tool		(First, Middle, Maiden Surna	ame)
To Be	Lewis Davis JR.	Ruth	Dixo	
F		dress (Street and Number or Rural		•
	Ruth D. Davis - mother 3711 1	ne Donogh Rd	Randauston	un, md. 21133
	20a. Method of Disposition 20b. Plece of Disposition 20b. Plece of Disposition cernetory, cremetory.	y or other place)	/ / /	- City or Town, State
	4 Donation 5 Other (Specify)	zion cem %	23/00 Lanso	downe, md.
E d	The state of the s	ma and Address of Facility Le	vis T. Gwynn	Funeral Home
2.80	Cluis & Luynn 451	7 Parkheights ,	Ave. Batto.	md. 21215-6393
	23a. Part1. Enter the diseasa, or complications that care ed the death. Do not enter the shock, or heart tailure. List only one cause on a chiline.	mode of dying, such as cardiac or	respiratory arrest,	Approximete Interval Between
ician dical	Immediate Cause (Final			Onset and Deeth
niner	disease or condition resulting in death) Terminal Aspiratio			10-15 min.
ě	Due to (or as a consequence	ce of):		
al Examiner	Sequentially list conditions. Calciphylaxis Due to (or as a consequence)	ea of):		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. End Stage Renal Di			
edical	that initiated events resulting in dealh) Last Due to (or as a consequence)			
	d			1
Physician/M	Dot II. Other significant conditions and its research.	des source et la Paris	20h Didash	
hys	Part II. Other significant conditions contributing to death but not resulting in the under		ADV AND	contribute to the cause of death? 3 Probably 4 Unknown
by P	Klebsiella Peritonitis, History of Oste	omyelitis (MRSA)	1 29(100	, , , , , , , , , , , , , , , , , , , ,
should be detected leted by Physic	Upper Gastrointestinal bleed, Hypertens	ion, Diabetes	24a. Wes an autopsy performed?	24b. Were autopsy lindings available prior to
v Q				completion of cause of death?
funeral director, page flon: To Be Com	Mellitus, Candidemia		1□Yes 2XNo	1 ☐ Yes 2 ☑ No
Be	25. Was case referred to medical examiner?	26. Place of Death		
. To	1 ☐ Yes 2 ☐ No	LI UUA 4 LI Nursing Hom	ne 5 Residence 6 00 8d. Describe how injury occi	- 1 1 1 1 1 1
tlon	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Work?	os. Dood Do How alluly Occ	
Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, 1			mber or Rural Route Number,
Certifi	4 ☐ Homicide building, efc. (Specify)		City or Town, State)	
edical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investignment of the control	urred et the time, date and place, ar pation, in my opinion, death occurre	nd due to the cause(s) and r	manner as stated
Med	one) and manner stated. 29b. Signature and fille of ceptitier /	29c. License number		ned (Month, Day, Year)
Medical Certifi				
10	20 Name and stated of course the same stated as a state of the same stated as a state of the same state of the same stated as a state of the same state of t	117211	Augus	ot 11, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print Maryam Kashi, MD 2.401 W. Bel	vedere Ave.	Baltimore	MD 21215
State	31. Dala tiled (Month, Dey, Year) ALIG 1 9 2000	1.	120011	1.10 2.10
Registrar	AUG 1 9 2000 Seneral 19	Goores		

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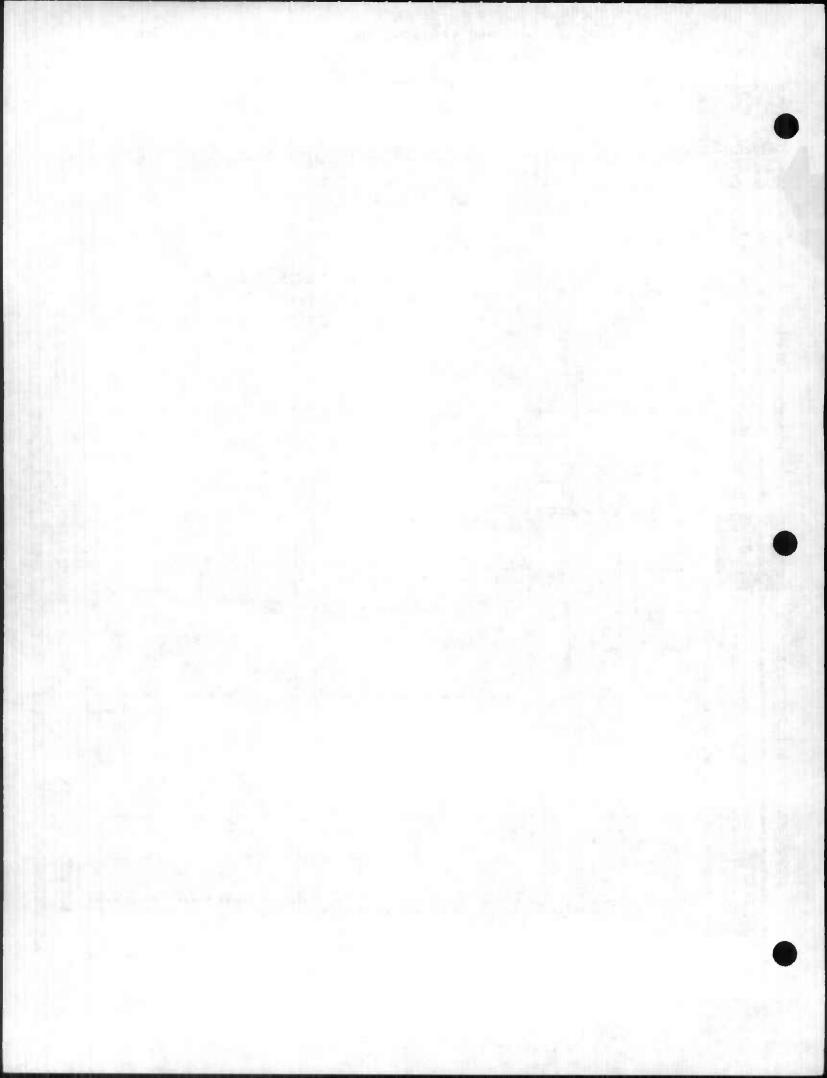
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			State of Mai		ertificate of	nealth and iv Death		Reg. No.	3 2	6336
Physic	ian	1. Decedent's Name (First, Middle, Las				YE STA	2. Dete of De		80°	3. Time of Death
/Med	cal	Barbara R. 4a Facility Name (If not institution, give	Eslinger			4b. City, Town, or Lo	August			11:10 PM
Exami	ner	187 9th Street				Pasaden	a	Anne		de1
Funeral Director		210-70-2303	ex 7. Age	(In yrs. last birthday 62 yrs.	Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da (March 2	1938 1938	9. Birthple Gount Mar	ace (State or Foreign Vland
the Maryland 7.28a-f show	tor	Usual Residence of Decedent 10s. Stete Maryland Anne Art	undel	10c. City, Town or L	Pasader	na			10	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
ath with the 23a or 28	Funeral Director	10e. Street and Number 187 9th Street			10f. Zip Code 2	122		10g. Citizen of W	A	
1215-0020 within 72 hours after death with the Maryland ene. than "natural," or hams 23a or 28a-f show he Medical Examinar must be notified.	þ	11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 X Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:		. Wes Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐XNo	tispenic Origin? (Spi en, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - America k, White, e Whit	etc.
21215-0020 d within 72 hours af giena. giena. r than "natural", or	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	edent's Usuei Occup re kind of work done DO NOT use retire	pation during most of work d)	ing	16b. Kind of Bu		
CV 77 75 10 10	omp	Elementary/Secondary (0-12)	College (1-4or 5+		ousekeepi			Nursin	g Horr	ie
yland 2 build be filed Mental Hygis srked other	Be	17. Father's Name (First, Middle, Last) Louis Cantler				18. Mother's Nemo		Maiden Sumam tchie	Θ)	
Mar d 2 sh sh and 7 is m traum	To	19a. Informant's Name/Relationship (19a)	**			and Number or Run te Rd., Wa	al Route Numbe	er, City or Town,		Code)
of Hear		20e. Method of Disposition 1 Buriat 2 Cremetion 3 4 Donation 5 Other (Specific	Removel from State		position (Name of ematory or other plater),	Too	ug. 18	20c. Location - Baltimo		wn, State Mary Tand
Baltimo		21. Signature of Funacul Service User	500		22. Neme end Addre		Stalling	gs Funer	al Ho	ome, P.A.
		23a. Part1. Enter the tisease, or companies, or heart failure. List only	that caused the caused tine	he deeth. Do not e	nter the mode of dyi	ng, such es cardiec	or respiratory e	rest,	1	Approximate tnterval Between Onset end Death
Physician /Medical		Immediete Cause (Final diseese or condition	Metrs	Boto	Bes	15T C	one	31		200
Examiner	_	resulting in death)		ue to (or es e cons					1	7
cuted	Examiner	Sequentially fist conditions.	b	ue to (or as e cons	equence of):					
68760, ficate be assecuted physician and s the burial-fransit	ai Ex	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	C						i	
OX 687 certificate inding physical	Medicai	resulting in death) Last	Di	ue to (or es a conse	equence of):					
Box (Beath certif	ician	Part II. Other significant conditions or	patributing to death but	not resulting in the	underlying cause of	en in Part I	23h Did	lohacco usa cor	tribute to	the cause of death?
ords, P.O. Box 68760, requires that the death certificate be assect een signed by the attending physician and hould be detached for use as the burial-fran	by Physician/M	Parti. Other significant conductions of	Jimbulang to death but	not resulting in the	underlying cause gr	on in Fait.	1 🗆	1	3 Prob	
/ D 10	Completed b							an autopsy rmed?	ave	ere autopsy findings eileble prior to appletion of cause death?
The lew	Com						10	Yes 2 No	1□	Yes 20 No
of Vital Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-FISON	Otl	26. Place of Deat	- 1		1015	
On of ding Phys. After this funeral d	tion: To	1 Yes 2 No 27. Manner of Death 1 Naturat 5 Pending investigation	1 ☐ Inpatient 28a. Dete of Injury (Month, Day	28b. Time	of 28c. Inju	4LI Nursing Ho		dence 8 Other		9
Division To the Hospital or Attendi within 24 hours after deeth To the Funeral Director: A completely filled in by the f	edicai Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, ferm, s (Specify)	street, lactory, office		28f. Location (: City or To	Street and Numb vn, State)	er or Rura	I Route Number,
Hospfu 24 hours Funera letely fille	dicai		yeician: To the best of siner: On the basis of e and menner stets	xamination and/or i						
To the vithir To the comp	Me	29b. Signature and litle of certilier	ly 1	1120	29c. Licens	se number / 457/	/	29d. Dete signed	d (Month,	Day, Year)
RÓ		30. Name and address of person who C. Thornas Folke		4231 Pos	e, Print)	, Pasaden	a, MD.	21122		
	ate	31. Dete filed (Morith, Day, Year)	32. Registraç							
Regist	rar	AUG 2 1 2	000 54	neva p) poor	Ks				

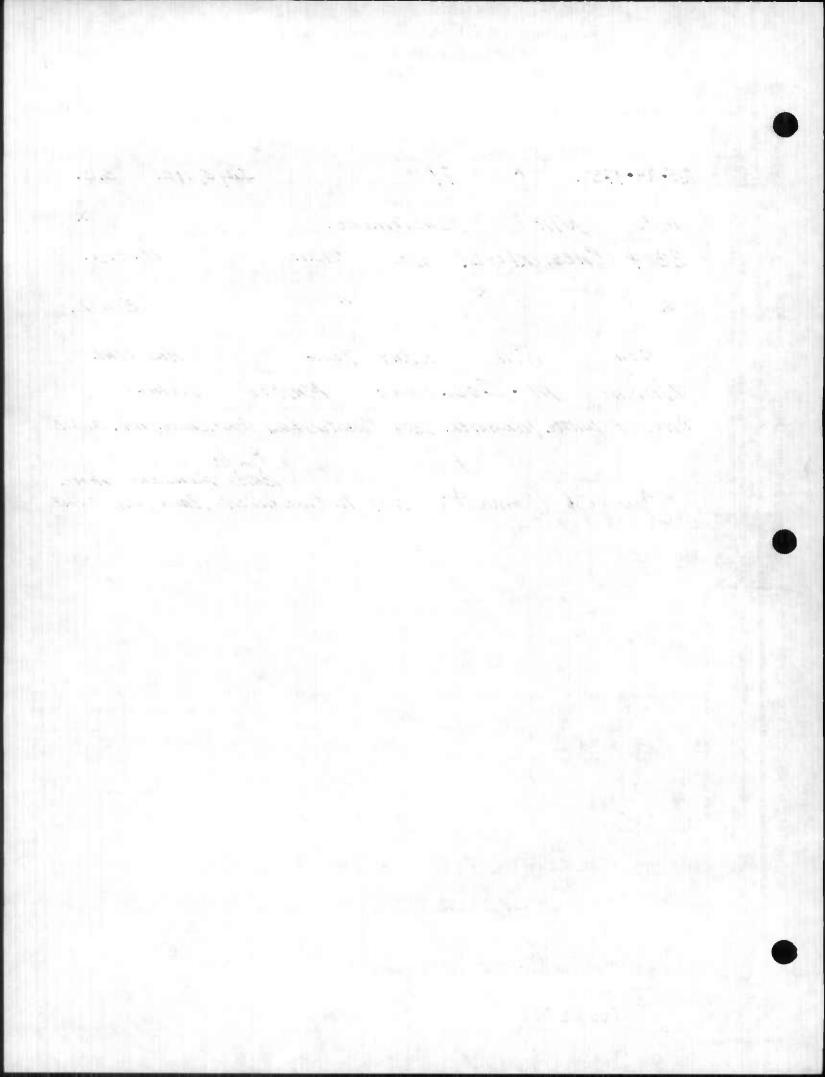
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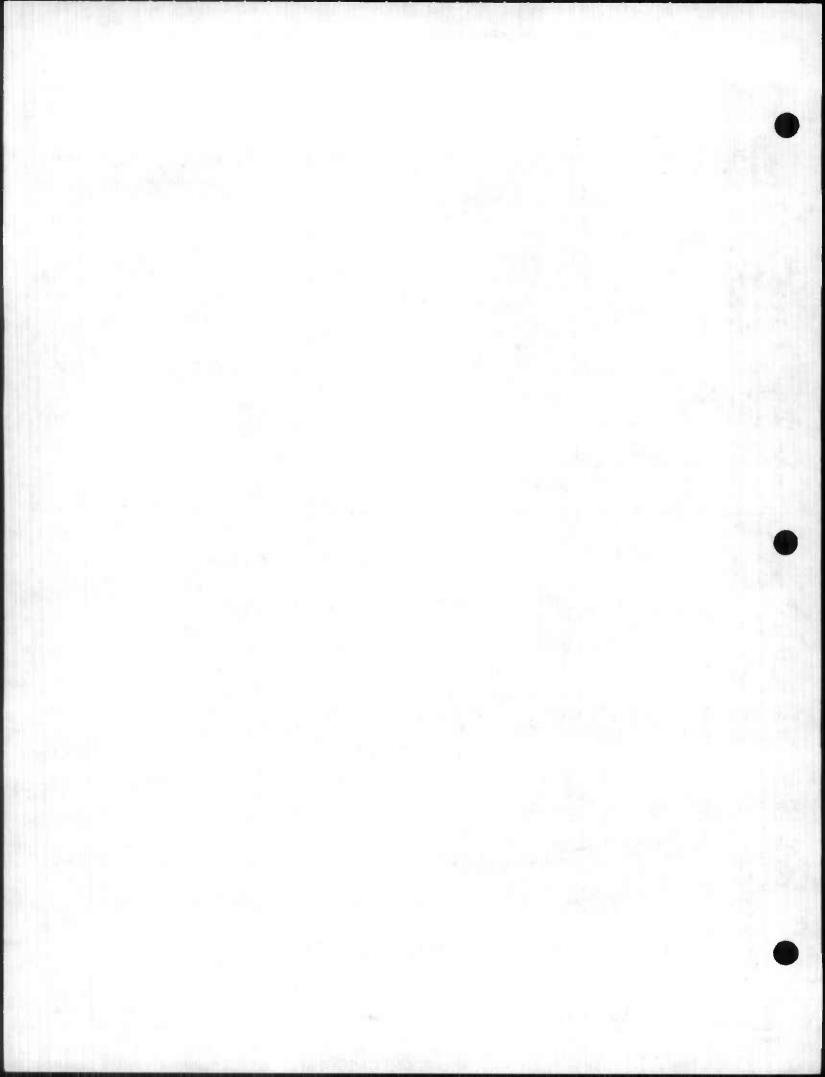
	Decedent's Name (First, Middle, L.	nst)		Certific	cate of	Death	2. Date of De	Reg. No.		3. Time of Death
ysician	Sallie Fost						Month 8	Day	Year	10:15 pr
Medical aminer	4a Facility Name (If not institution, gi	1	NYT.			4b. City, Town, or			of Death	
	Genesis Ham			Harford '		Balto, M			HM	
eral ctor		Sex 7. Age 1 ☐ M 2 ☐ F	In yrs. le		Inder 1 Year oths Days			rth ey, Year) , 1921	Count	ace (Stele or Foreig ry) . C .
H	10a. State 10b. County		10c. City	, Town or Location					10	d Inside City Limits
ctor	md. N	IA	13	BALTIN.	PORE					1 Yes 2□No
Dire	10e. Street and Number	. 0		10	f. Zip Code	- 7		10g. Citizen of V		
le le	3304 CHES	TERFIEL	d	AVE		1213	Canaity Van as N		- S.)	
by Funeral Directo	11. Meritel Status 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		If Yes,	specify Cui	Hispanic Origin? (ban, Mexican, Pue Specify:	nto Rican, etc.)		k, White, e	
	15. Decedent's E			16a. Decedent's	Usual Occu	pation		16b. Kind of Bu	siness/Ind	ustry
nple	(Specify only highest gi	College (1-4or 5-	+)	life. DO N	OT use retin	e during most of wo	жинд	./		
S	774	NIA		XRAY	70	CH Notherdalla	ma /Final & Aintelle	HOSP	ZTA	6
To Be Completed	17. Father's Name (First, Middle, Las		046	011/11	,	Alarra	ime (First, Middle	, Maiden Sumam		
ĭ	19a. Informant's Name/Relationship		166		dress (Stree	et and Number or F	Rural Route Numl	21111		Code)
	PAISEY WHI	C 1	ree	3304	CHEST	ree fico	. 1	BALTO, 1		
	20a. Method of Disposition		20b. Pt	ace of Disposition	(Name of or other place)	ace)	Date	20c. Location -		
	1 Burial 2 Cremation 3 d 4 Donation 5 Other (Spec		KI	NG ME	MORI	al PK	8/22/00	KANda	115 700	UN, Md
	21. Signature of Funeral Service Lice	msee	,	22. Nan	ne and Addr	ress of Facility	SETTS 1	UNERA	26 1	HOME
	Bener 4A	Cromar	til	1129	n.			BALTOS.	mp	21213
Ю	23a. Pant. Enter the disease, or cor shock, or heart failure. List only	nplications thet caused y one ceuse on each line	the deeth e.	. Do not enter the	mode of dy	ring, such as cardie	ac or respiratory	arrest,		Approximete Interval Between Onset and Death
Е	Immediate Cause (Finel		(7,10					- 1	Da.
	disease or condition resulting in death)	a	Dun 10 (00	NA	41:	3000			1	1 4 NINO F
ner			Due to (or	as a consequenc	a 01):					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or	as a consequence	e of):				1	
dical	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or	as e consequence	of):					
Me		d		1250						
clan							L ear Di		1	
Physician/Me	Part II. Other algnificant conditions	contributing to death bu	t not resu	iting in the underly	ing cause g	jiven in Paπ I.		Yes 22 No		the cause of death
by P										
Completed							24a. Wa	s an autopsy ormed?	COL	ore autopsy findings tilable prior to inpletion of cause death?
COM							10	Yes 2010	10	Yes 2 No
Be	25. Was case referred to medical examiner?						eath (Check only	one)		
5	1 Yes 2 No	Hospital:			1 DOV			idence 8 Oth)
- Lo	27. Manner of Death 1. Natural 5 Pending investigetic	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Inj	ork? ☐ Yes 2 ☐ No	28d. Describe	how injury occur	190	
Certification:	3 Suicide 6 Could not	00 - 0111	iry - At ho	me, farm, street, fa			28f. Location	(Street and Numb	er or Aura	l Route Number,
ert	4 Homicide	building, efc.	. (Specify)			City or To	iwn, Stete)		
edical		hysicien: To the best of miner: On the basis of a	examinati							
×	29b. Signature and Alle of certifier		11111		29c. Licer	nse number		29d. Date aigne	d (Month, i	Day, Year)
	1/1/2	1			1	454	15	8/1	8/1	00
	30. Name and address of parson who					0	4	1	1	
	31. Date filed (Month, Day, Year) AUG 2 1	RFZA T		HWAM	4	GENES	FS HA	milion	7	11.5
State	31. Date filed (Month, Day, Year)	32. Registra	er's Signat	ure la	1	1				

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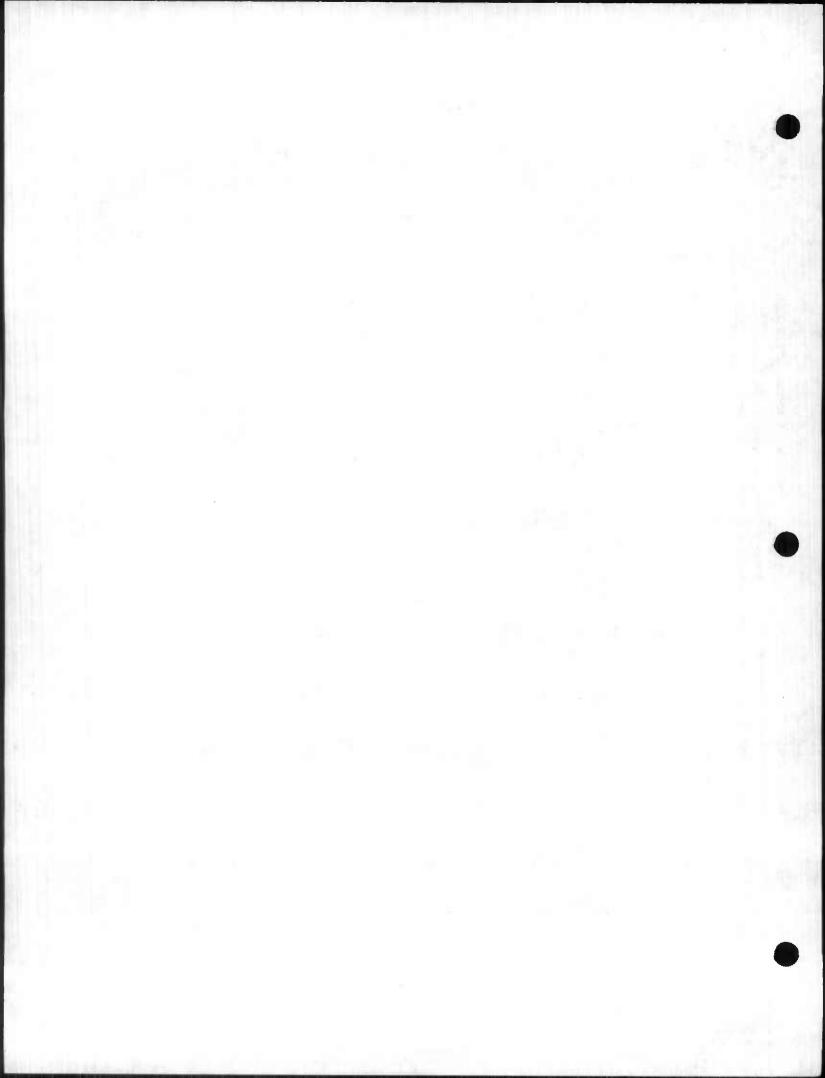
			C	ertificate	of Death	7	Re	g. No.	0 5000
Dhyaisian	1. Decedent's Name (First, Middle, Li	ist)	1 - 51/4	La Circle			Date of Death		3. Tima of Dea
Physician /Medical	SAMUEL		FRANK						7:20AM
Examiner	4a Facility Name (If not institution, gir FUTURE CARE— CHER		SING HOME		REIST	ERSTOW		4c. County BALT	of Death CIMORE
Funeral Director	216-10-9633		(In yrs. last birthda 36 Yrs.	Months C	reer If Unde lays Houra	Min. A	Date of Birth	^Y 13914	Birthplace (State or For Mountry)
after death with the Maryland or Itama 23e or 28e-f show prinet must be notified at Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD BALTIMOR	E	10c. City, Town or OWINGS M						10d. Inside City Lir 1 ☐ Yes 2 🔀
ifter death with the Ma r itsma 23s or 28s-1 s instrument be notified. Funeral Director	10e. Street and Number 4601 SPRINGWATER	COURT APT.	В	10f. Zip Co				g. Citizen of V J.S.A.	Vhat Country?
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and 2 should seith and Mer 127 is marks er traumatic	19a. Informant's Name/Reletionship MRS • SYLVIA FRANK								State, Zip Code) MILLS, MD. 211
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ystolen: The leving is certificate hes director, page 2.							1 ☐ Ye	s 200 No	1 Yes 2 No
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오름등드 등	3 Suicide 6 Could not to determined		ry - At home, farm, (Specify)	street, factory, o	ffice	28	Location (Str. City or Town,	eet and Numb , State)	per or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cerl	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nyaician: To the best of miner: On the basis of a and manner state	examination and/or	ath occurred at I Investigation, in	he time, date a my opinion, de	and place, and eath occurred	d due to the ca at the time, da	use(s) and ma ite and place,	anner as stated. and due to the cause(s)
within Toth comp	29b. Signature and title of control	us	MA	29c. L	icense number	756	29	d. Date signe	d (Month, Day, Year)
9	30. Name and address of person who	completed galiserol de	ath (Item 23a) (Typ	e, Print)	Cori	uni	Tree	Red	# 300
State Registrar	31. Date filed (Month, Day, Year) AUG 2 1 20	32. Registrar	's Signature	lac	1		1,0	100	



State of Maryland / Department of Health and Mental Hygiene

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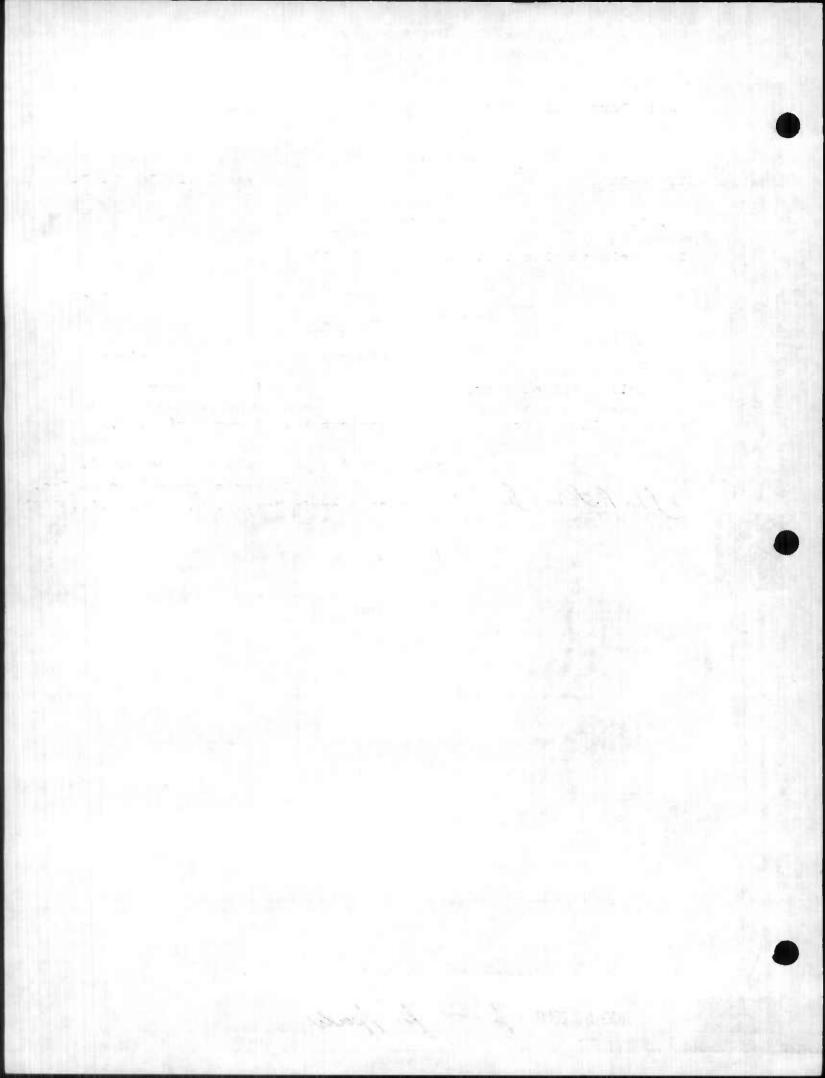
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	19a. Informant's Name/Ralation JOHN D. CALLAN/									MD. 21	er, City or Town	n, Stata, Zip	Code)	
	20a. Mathod of Disposition TD Burial 2 Cramation 4 Donation 5 Other (moval from	State	. Place of Disposers, cr. CBREW F	amatory or	othar plan	ce)	8/	Data /18/00	20c. Location			
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Disease or Injury that initiated events rasulting in death) Last b. Due to (or es a consequence of): c. Due to (or as a consequence of):												5		
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			State of Ma	aryland		ment of I	Health and M Death		iene	00 2	6340
		1. Decedent's Name (First, Middle, Las	st)					2. Date of Deat			Tima of Death
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Exam	iner	Doctors Com		HOSP	ital		Lanhan	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2 Geor	(
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aryta asho	-										X Yes 2 No
2 24	ctc	D. C.		Wa	shingt						27.00 20.00
5 6	눔	10e. Street and Number			1	10f. Zip Code		1	0g. Citizen of V	Vhat Country?	
death with the Maryla irre 23s or 28s-f shor ir must be notified at	7	3357 Holmead P	lace, N.	W.		200	10		USA	4	
2 5	Funer	11. Maritel Status	12. Was Decedent Armed Forces?	Ever in U,S	3. 13. Was	Decedent of	Hispanic Orlgin? (Spoan, Mexican, Puerto	ecify Yes or No- Bican, etc.)		a - Amarican fn k, White, etc.	dian,
1 29	2	1 Never Merried 2 Merried	1 Yes 20 M	No		Yes ZZNo				- 7	a k
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a day	0 0	Charlie Wil	son Perr	V			Maggi	e Lee	Perrv		
2500	F	19a. Informant's Name/Relationship (Type Print)	-	19h Mailing A	Address (Stree	of end Number or Run			State. Zip Code	e)
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2 2 2 2 2		20a. Method of Disposition	5011	20h Pis	ace of Disposition		te Ra., 51			City or Town, S	
10 10 10		1 Burial 2 Cremation 3	Removal from State	Ce	metery, cremeto	ory or other ple	ece)	Duito	LOG. LOGGIO	only or rount, c	31010
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I BOOK		21. Signature of Funeral Service Licen	see	ccast	. O 22. No	ame and Addr	ress of Facility Latr	ev's F	uneral	Home	. Inc.
20119		John maalu	uy Jr.	CC034	383		rgia Ave				
Physician		23a. Part1. Enter the diseese, or comp shock, or heart failure. List only	plications that caused one cause on each lin	the deeth.		he mode of dy	ing, such as cardiec	or respiratory arre	est,	App	roximate rvet Between set and Death
/Medica Examine	1	Immediate Cause (Final disease or condition resulting in death)	a			-	Infar	ction		(5 days
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nsit ned	Examiner						Cardiov	uscular	PIJE	416 16	years
and and	xai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or	es e consequen	nce of):					
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de de	Physician/Medi	Part It. Other significant conditions co	ontributing to death be	ut not resul	lting in the unde	rlying cause g	iven in Part I.	23b. Did to	bacco use co	ntribute to the	cause of death?
at the	Phy	CD. CT. (C.	1 10 11	m 0				1 U Y	ss 200 No	3 Probably	4 ☐ Unknown
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The law requires that the death certificate are bas been signed by the attending physpage 2 should be detached for use as the								24e. Wes a	n autopsy		utopsy findings be prior to
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he law	Completed							400	· om/	100	
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	on:	27. Manner of Death 1 □ Maturel 5 □ Pending	28a. Dete of Inju (Month, De		28b. Time of Injury	28c. inju		28d. Describe ho	ow injury occur	red	
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phat or Attending hours after death. meral Director: After y filled in by the fune	Certification:										
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To the complex	3	29b. Signature and title of certifier			0 0	29c. Licer	nse number	2	9d. Date signe	d (Month, Dey,	Year)
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110	0	30 Name and address of narray who	completed course of d	poth /liam	230) (Time Dais	111					
1	0	30. Neme and address of person who co	completed cause of d	eath (Item	23a) (Type, Prir	4850	Furbes (31-d La	h hap	, m z	0706

Registrar

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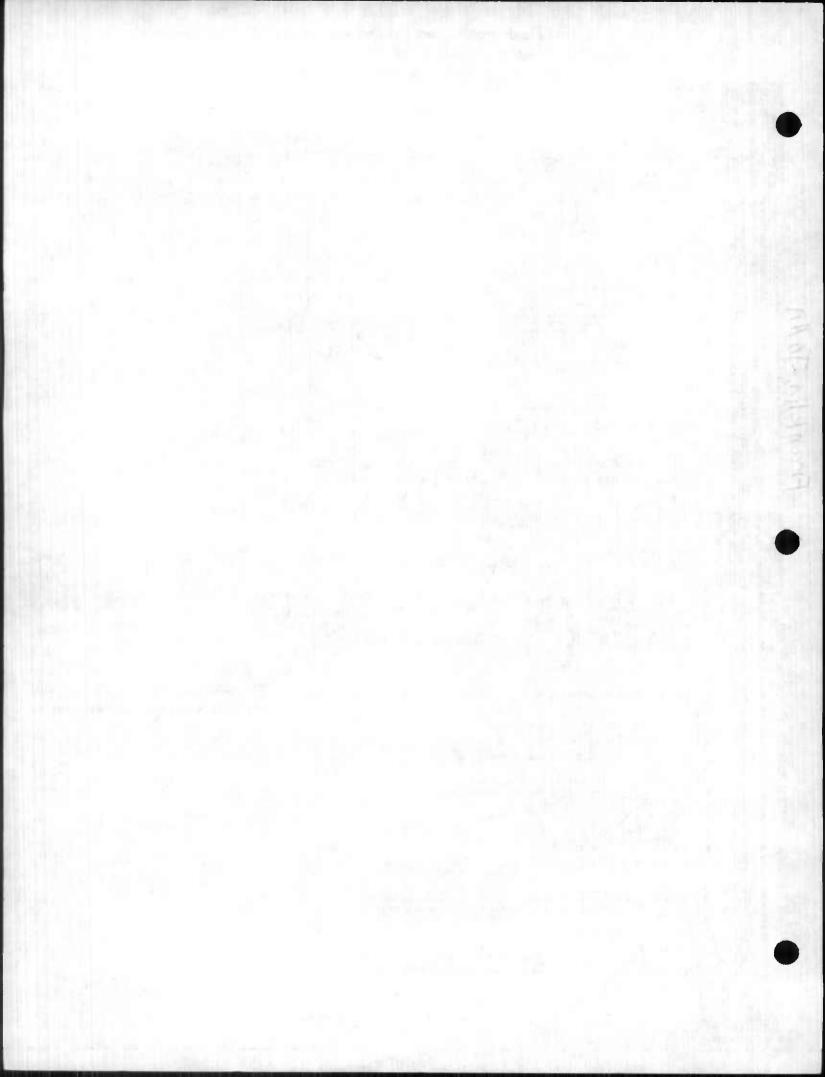


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** FRANKLIN W. AUGUST JOAN 15 2000 4:15am /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Yeer If Under 24 Hrs 6 Say 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 214. 26. 0420 Usual Residence of Decedent 06-14-Director 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene.
Important: If item 27 is marked other than "natural", or Nama 23s or 28s-4 show withingty or other treumatic event, the Marical Examples must be notified an once. 1 Ves 2 No mo NIA Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 21234 DOWLING CIRCLE USA Funeral 12. Was Decedant Eyar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 11 Marital Status Yas 2 No f Yes, Give Yeer or Detes: 1 Nevar Married 2 Married 1 Yes 2 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) College (1-4or 5+) DOMESTIC HOME 1211 GRADE NI 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) U. OTIS WHITE 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Streat and Number or Rural Route Number, City or Town, Stete, Zip Coda) GILES ELMIRA DAUGHTER BALTO. 24 DOWLING CIR. 20b. Pleca of Disposition (Name of cemetary, cramatory or other plece) 20e. Methed of Disposition Deta 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stefa 8.18.00 RANDAUSTOWN, KING PARK CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name end Addrass of Fecility VALGHN C. GREENE FUNERAL SERVICE 5151 BAUTO. NATL' PIKE, BAUTO. MO. 21229 Approximata Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the cleeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or hear failure. List only one cause on each line. Physician Immedieta Causa (Finel disease or condition rasulting in daath) /Medical da Examiner Dua to (or as a consequence of): Physician/Medical Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in death) Last ed by the attending physician and detached for use as the buriel-fren Due to (or es a consequenca of): The law requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, Due to (or es e consequença of) Pert II. Other significant conditions contributing to daeth but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings svailable prior to completion of causa of death? 24e. Wes an eutopsy performed? Completed After this certificate has 1 ☐ Yes 2 ☐ No 1 Yes papital or Attending Physicien: Thours after death.
Inexal Director: After this certificate y filled in by the funeral director, pa Be 25. Wes case rafarred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 Suicide 28a. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homlcide within 24 hours a Torthe Funeral C Hospita Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar steted. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifian 5-00 m 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) TIMORE. MD 21201 8 unden 31. Deta filed (Month, Day, Year) 32. Registrar's Signatura State Registrar AUG 19 2000

ORIGINAL

DHMH 16 Rsv 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26342 amend item 20a, 18 per fh G786 8/21/00 yg Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8 8:15 p.m MARY GERHARDT /Medical Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Choice Buckinghams trederick If Under 1 You Months De 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 20 F 98 Yrs. 218-32-5580 Director Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notined at Adamstour 1 Yes 2 No Director device 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21710 Levs irche Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status 72 hours after 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2NNo Specify by 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "na eny injury or other traumatic aventance. Elementery/Secondary (0-12) College (1-4or 5+) Health URSE 18. Mother's Name (First, Middle, Maiden Surname) Grace Hamer, 17. Father's Name (First, Middle, Last) Be rank Tadou P 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Westminster, Md. 21152 Mayne Gadow /nephew 3303 Bountiful Dr. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal Irom State 4 Donetion 5 DOther (Specify) Hilltop Service Corp. 8/19/00 Towson, Md 21. Signature of Funeral Service License 22. Name end Address of Fecility 1050 York Rd Towson mo 21204 tunera Inc lowson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Physician/Medical Examiner the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last end Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 200 3 Probably 4 Unknown should be det 2 Completed 24b. Were autopsy lindings available prior to 24a. Was en autopsy performed? completion of cause of death? enerter 22 No 1 ☐ Yes 2 ☐ No certificata 1 Yes funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: Medical Certification: To 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify)

P.O. Box 68760, or Attending Physician: The tew requires that the deeth certificate Division of Vital Records.

Baltimore, Maryland 21215-0020

Gerhard

s after deeth. filled in by within 24 hours a To the Funeral D To the Hospital completely

State Registrar

31. Date filed (Month, Day, Year) AUG 2

29b. Signature and title of certifie

2000

4 Homicide

29a. Certifier

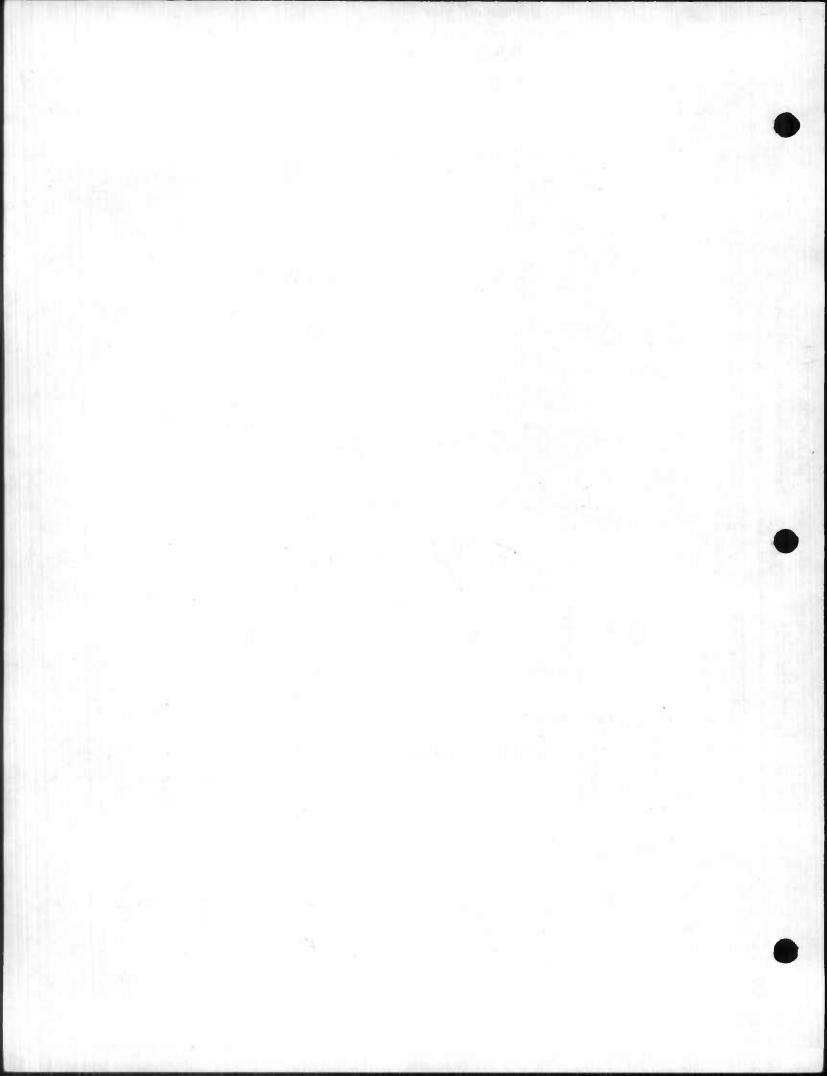
29c, License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

leer 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene | | 26343 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 15, 2000 DAVID P. CORDON 8:45 PM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not Institution, give street end number) **Examiner** GILCHRIST CENTER - HOSPICE OF BALTIMORE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Dete of Birth Month, Dev. Year) 09/22/1914 Birthplece (State or Foreign Country)
 NEW YORK 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 ₩ M 2 □ F 215-18-6926 85 Yrs. Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County MD BALTIMORE BALTIMORE 1 Yas 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8 5 GREENLEA DRIVE 21208 U.S.A. 238 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) ATTORNEY LAW 5+ 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Mental CHARLES **GORDON** FRIEDA FUERSTEIN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. VIRGINIA GORDON / WIFE 5 GREENLEA DRIVE, BALTIMORE, MD 21208 f Health. Item 27 i 20e. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stata ARLINGTON—CHIZUK AMUNO Burial 2 Cremetion 3 Removel from Stete 8/18/00 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) CONG. 22. Neme and Address of Fecility 21. Signeture of Funerel Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Total 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical weeks Examiner Examine sician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last 68760 edicai Due to (or as e consequence of): Box (Physician/M Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown Cardio Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) Hospice 1 Yes 2 No 10 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: Division Hospital or Attending 5 Pending Investigation 1 Neturel 2 Accident after death. Director: Af 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner es stated.

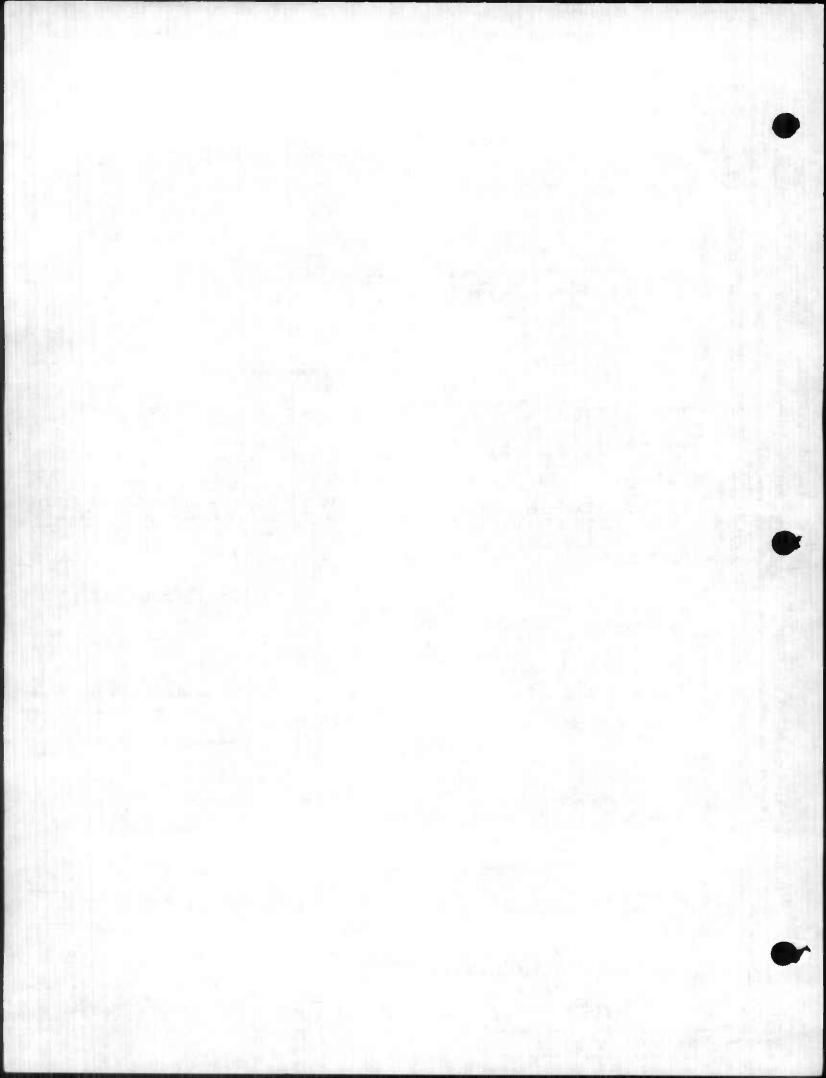
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stetad. 29a Certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier un m 23a) (Type, Print) 30. Name and address of person who completed cause of death-ry Charles St. GBMC 670

Registrar

State

31. Dete filed (Month.

32. Registrara Signatura



State of Maryland / Department of Health and Mental Hygiene 26344 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Deeth 2. Dete of Death Month **Physician** John D. Greene 14,2000 11:33 PM August /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Funeral Months Days 1₺ M 2□ F 578-18-9364 80 Director Aug.4, 1920 Washington, D.C Usual Residence of Deceden 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28s-f show 1 U Yes 2 □ No Director MD Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 5005 Lee Jay Drive, #103 20743 Nome 23a U.S.A. Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status o filed within 72 hours efter de Il Hygiene. other than "natural", or frem Black, White, etc. 1 2 Yes 2 No N/A
If Yes, Give
Year or Dates: 1 Never Married 200 Married Baltlmore, Maryland 21215-0020 Specify: Black 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seeondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed we Department of Health and Mental Hygien Important; if hem 27 is marked other the any hojury or other traumatic event, if an once. Private Cab Driver 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John D. Greene, Sr. Isabelle Dowe 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Green-Wife 5005 Lee Jay Dr., Capitol Heights, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Maryland National Park 8/18/00 Laurel, MD 21. Signature of Funerat Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. CC0348 3831 Georgia Ave., NW, Wash., DC Latuel Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The lew requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the buriel-trans Due to (or as a consequence of) Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 987 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown Records, þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed hes 1 Yes 2 PNC 1 Yes 2 No Division of Vital 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpetient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 5 Pending investigation or Attending n 24 hours after deeth, ne Funeral Director: Afte blately filled in by the fun 1 TYes 2 TNo 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral D 29e. Certifier 10 certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated. on the basis of exam (Check only nination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed, (Month, Day, Year) 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

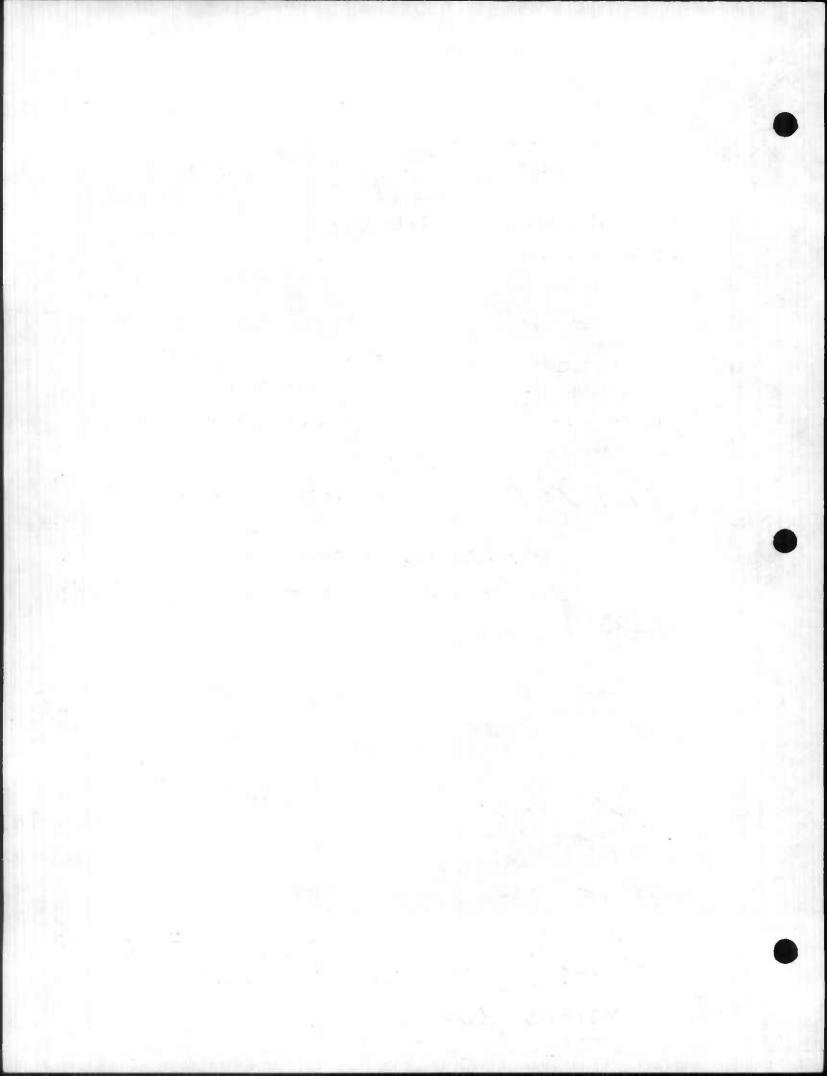
31. Date filed (Month, Day, Year)

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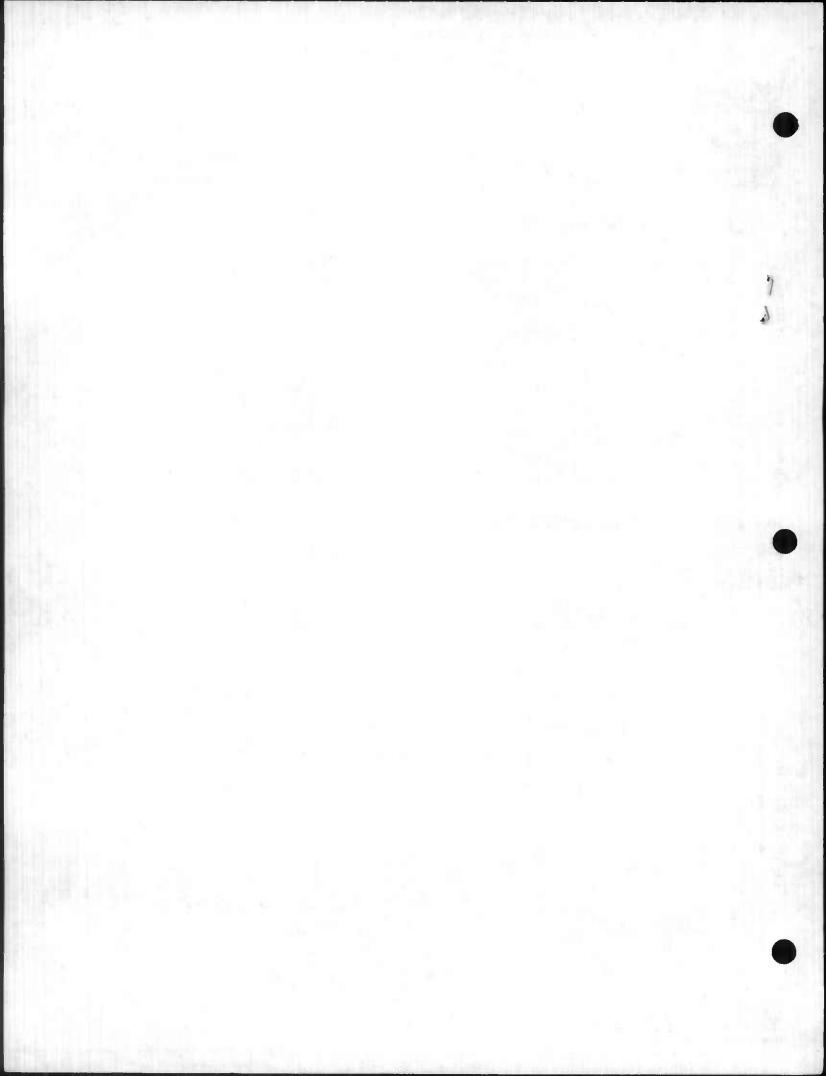
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Signature



State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death Reg. No.	26345
	Decedent'a Name (First, Middle, Last) Decedent'a Name (First, Middle, Last) Decedent'a Name (First, Middle, Last) Decedent'a Name (First, Middle, Last)	3. Time of Death
Physician /Medical	DAVID GIBSON 08 16 2000	3:00 Am
Examiner	4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	- 1
76 - 11 hrs	The Good Samaritan Hospital Baltimore Baltimore Baltimore	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birth (Month, Day, Year) 9. Birth (Month, Day, Year)	thplace (State of Foreign buntry)
ahow ahow	10a. State 10b. County 10c. City, Town or Location	t0d. Inside City Limits
the Maryle 28a-f aho notified a	WATYLOND M/B BALTIMORE	12 Yes 2 □ No
With the board	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co	
020 020 by	3 ☐ Widowed 4 ☑ Divorced Year or Dates: Specify: Specify: Specify: Specify:	le, etc.
72.72 72.78 natur	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 4 ARES LI	
121215-00 ed within 72-70 yojene. Per than "naturunt, in wooden	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Maintenace (Give kind of work done during most of working life. DO NOT use relired) HANES LIFE CONTROLL	neserry
N pak	5 B Grade Maintenna (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme)	
yiand yiand Mental H Mental H mitcaven	WILLIE LEE GIRSON JOSEPHINE WHITE	
Maryland 2 d 2 should be filed th end Mental Hygi 7 is marked other traumatic avent. To Be Co	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, and Number or Rural Route Number, and Number or Rural Route Number, and Number or Rural Route Num	
Total	IDA Dryges / Daughter 6228 CATAIDNA RUMO BALTHUES, And 21.	
0 82 = 8	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place)	Town, State
aitim nit. Pagartimortant: injury	4 Donation 5 Other (Specify) Pleasant Rest Cometagy / Jous on, Me	ary cano
Baitim permit. Pa Departmen Important: any injury	21. Signature of Funeral Service Licansee 22. Name and Address of Facility (DA THAN - HAMM) FOR SERVICE RESIDENCE AND SERVICE PROPERTY AND SERVICE PROPERTY OF SERVI	THE HOME
10-000	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician		Onset and Death
/Medical Examiner*	Immediate Cause (Final disease or condition resulting in death) Respiratory failure a. Respiratory failure	13 days
	Due to (or as a consequence ot):	12 days
executed in end interest	Sequentially list conditions b. Jilleumonica. Due to (or as a consequence ot):	13 dely
68760, ficate be executed physician end as the bunal-transit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	13 deus
68760 ficate be en physician as the burial Edical E	Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence ot).	
	C- I blending	7 days.
death death death of for all cla	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute	s to the cause of death?
P.O. that the de by the detached	1 Yes 2 No 3 P	Probably 4 Unknown
dS, Figures the signed dbe de	primonary Emborism, DNI, COPD	
requirements	Asthma, Angina, Parkinson's disease 24a. Was an autopsy performed? 24b.	Were autopsy findings available prior to completion of cause of death?
f Vital Recognitions The law sentificate hes director, page 2	HTN, CVA, Anemia, Dementia, Depression 1 Yes 20 No 25. Was case reterred to medical 86. Place of Death (Check only one)	1 ☐ Yes 2 ☐ No
yaicia s cent direct	examiner? 1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Residence 2 ER/Outpatient 3 DOA Other (Specific Residence 2 ER/O	ecify)
on of aling Phys. h. After this funeral di	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 28c. Injury at Work?	
Vision of Vita Attending Physician: ardeath. ector: After this certification: by the funeral director, liffication: To Be C	2 Accident Investigation M 1 Yes 2 No	
Division or Attend after death Director: /	3 Suicide 4 Homicide 4 Homicide 4 City or Town, State) 28e. Place ot Injury - At home, farm, street, tactory, offica building, etc. (Specify)	tural Houte Number,
Division C To the Hospitat or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Certification:	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner at manner at my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner at and manner stated.	
Within on the	29b. Signature and title of certifler 29c. License number 29d. Date signed (Mon	th, Day, Year)
	Vinglin (100, MD) P14417 ,8/16/00	
Di	30. Name and authors of person who completed cause of death (Item 23a) (Type, Print) Attach HOSPITIAL	
State	31. Date tiled (Month, Day, Year) 32. Registrar's Signature	
Registrar	AUG 1 9 2000 Breeze 10 populars	



00-4606-003 ihm DAVID VERNON HANNA 1. Decedent's Name (First, Middle, Last) **Physician** David V. Hanna /Medical **Examiner** OLD MILL PARK 5. Social Security Number **Funeral** 10XM 2□ F 214-06-9873 Director Usual Residence of Decedent 10e. State 10b. County Directo Maryland Anne Arundel 10e. Street and Number 6 7861 Red Lion Way 238 Funeral 11. Marital Status 1 X Never Married 2 ☐ Merried 6 3altimore, Maryland 21215-0020 Àq 3 Widowed 4 Divorced Completed 15. Decedent'a Education (Specify only highest grade completed) Elementery/Secondery (0-12) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental ant: if them 27 is merked o James Hanna 19a. Informent's Neme/Relationship (Type, Print) James Hanna (father) 20e. Method of Disposition 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Euneral Service Liceru Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medicai Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Dete of Deeth Dev 15, 2000 23:28 PM AUGUST 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Millersville ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Feb. 24 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Months Days Hours Min 31 Yrs. Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Pasadena 10g. Citizen of What Country? 10f. Zip Code 21122 Anne Arundel 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) l ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Mexican White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Heating & Air Condit. Technician 18. Mother's Name (First, Middle, Maiden Surneme) Cruz Trevino 19b. Mailing Addresa (Street end Number or Rural Route Number, City or Town, State, Zip Code) 8086 Wolsey Court, Pasadena, Maryland 21122 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Aug 2000 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Metro. Cremetory, Inc. Baltimore, Maryland 22. Name and Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 23a. Parft. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each me Onset and Death Hanging
Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

The law requires that the deeth certificate be exact es the signed by þ Be Completed page or Attending Physician: the funeral director, Medicai Certification: To After this death.

Box 68760,

P.O.

Division of Vital Records,

1 | Yes 22 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed?

1 Yes 2 □ No 1 XYes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 MOther (Specify) SCENE Yes 2□ No 28a. Date of Injury
(Month, Day Year)

Found

8-15-2100 Unit now M 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? hanged self 5 Pending investigation 1 Naturat Subject 1 Yes 2 No 2 Accident 6 Could not be

3 Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) O(d Mil) Pank 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Par | 7 Anne Arundel County, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

OCME

29b. Signeture and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) AUGUST 16, 2000

30. Name and address of person who completed cause of deeth (Item as) (Type, Print)

Stephen S.
31. Date filed (Month, Dey, Year) adentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

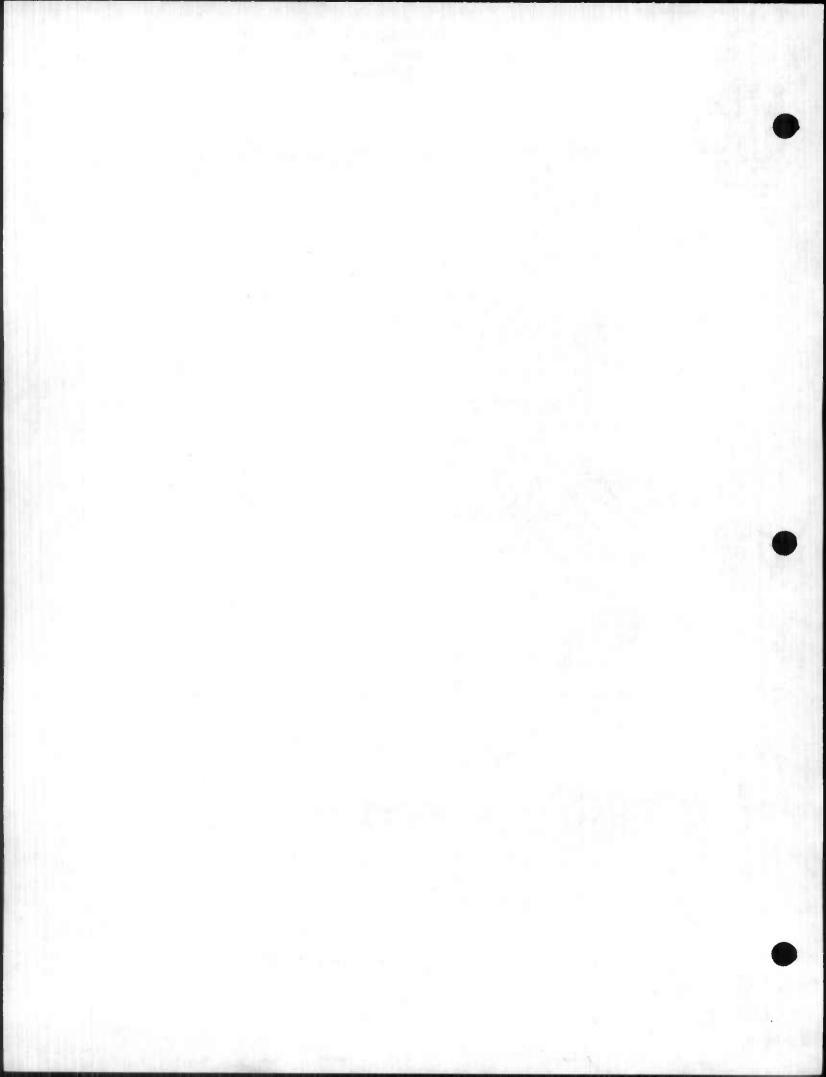
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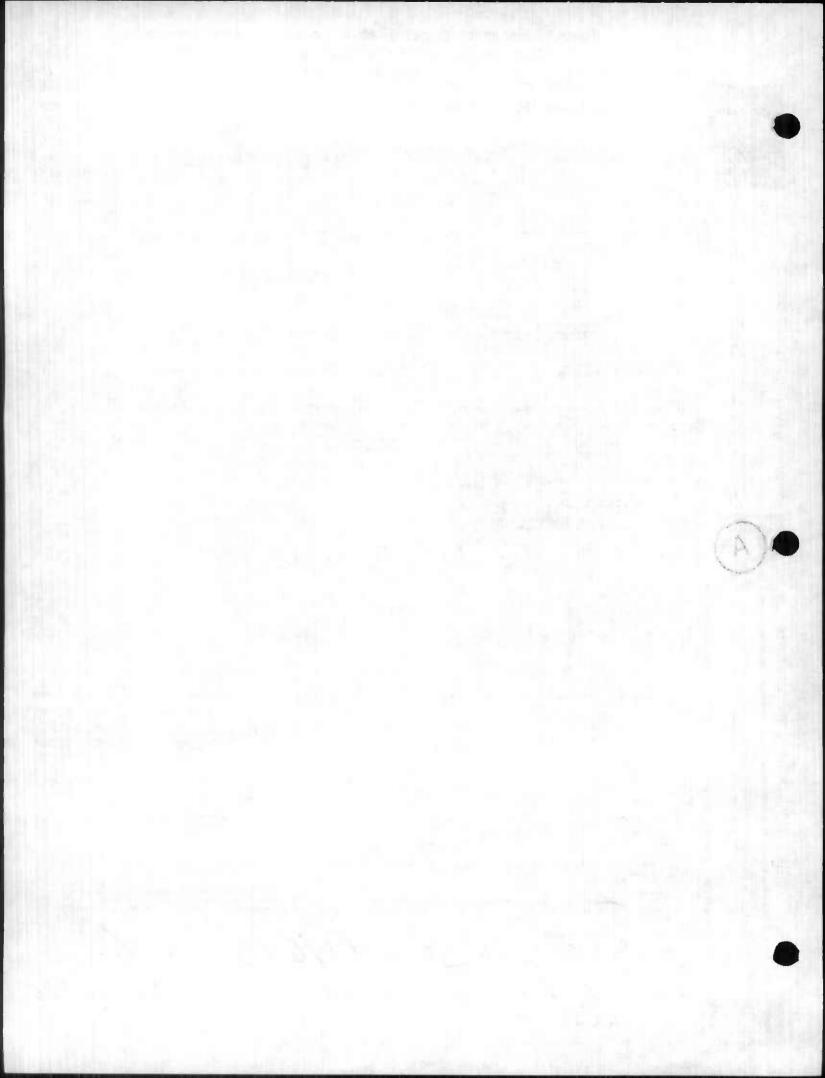
To the

fitted in by

completely



Physician	1. Decedent's Nama (First, Middle, Last) Bartholomew F. Hines	2. Data of Death Month	Day Year	3. Time of Death 6:25 p.m
/Medical Examiner		August r Location of Death	7, 2000 4c. County of Dea	,
LAGIIIIIEI	St. Joseph Manor 911 W. Lake Avenue Balti	more	N/A	
Funeral Director	5. Social Security Number 022-10-2490 6. Sex 1 DM 2 F 7. Age (In yrs. last birthday) 83 Yrs. 83 Yrs. 6. Sex Hours Mi		^(ear) 9. Bir 1917 Ma	thplece (State or Foreign ountry) SSACHUSETT
š 11	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit
af sho iffed at	Maryland N/A Baltimore			1 Yas 2 N
or 25e-fr	10e. Street and Number 10f. Zip Code	10g	. Citizen of What C	
	911 W. Lake Avenue 21210		United	
ar, or hams 23. Examinar must by Funeral	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forces? 1 Nevar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put Mexican	Specify Yes or No- erto Rican, atc.)	14. Race - Ame Black, Whi	
dicai.	15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	orkina 16	b. Kind of Business	/industry
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Mental H erked ott atic ever To Be		lizabeth		
ment ment	19a. Informant's Name/Relationship (Type, Print) Fellow 19b. Meiling Address (Street end Number or Information of the Informati			Zip Code)
of the	Very Rev. Robert Kearns, S.S.J./Priest 1130 N. Calvert Street	et Baltimo	ore, Mary	land 21202
T T T T	20a. Melhod of Disposition 1 🛱 Buriai 2 Cremation 3 Removal from State	Date 20	C. Location - City or	Town, State
Sury o	4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery	8/11/2000		
my in	21. Signature of Funeral Service Licensee Michael E. Canapp 22. Nama and Address of Facility		05 Harfor	
da	LEONARD J. RUCK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi			MD 21214
physician and s the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated avents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es a consequence of):			
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igned by be detac by Ph		1 Yee	2 4No 3 1	Probably 4 Unkn
2 should		24a. Was an performe		Were autopsy finding aveilable prior to completion of cause of death?
Of Vital RECORDS, Physician: The lew requires this certificate has been signs rail director, page 2 should be To Be Completed by		1 □ Yes	2 D/No	1 ☐ Yes 2 ☐ No
director, pag	examiner? Hospital: Other	eath (Check only one)		
this aldi	27. Manner of Death 1	28d. Describe how		ecity)
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Stre City or Town,	pet and Number or F State)	Rural Route Number,
n 24 hours he Funera pletely fille edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plated the control of the basis of examinetion and/or investigation, in my opinion, death occurred and manner stated.	ce, end due to the cau curred et the time, det	use(s) and manner e e and placa, end du	es stated. e to the ceuse(s)
CALC OF	29b. Signatura and title of certifier 29c. License number	290	d. Date signed (Mor	My Day, Year)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26348 Certificate of Death AMND ITM#5 PE. F.H. G802 12-18-01 JAB 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day **Physician** 4b. City, Town, or Location of Death THEL HAWKINS 15,2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner northwest RAMONIIS FOUN Hospital Baltimore Center 5. Social Security Number ff Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 28 F 100 1,1900 W. Vieginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 1 Hos 2 □ No BAHHUER Director 10e. Street and Number 28a-f 10f. Zip Code 10g. Citizen of What Country? b SEQUOIA AUG 21211 U 517 3701 florns 23a Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - Amarican Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 Specity: Black 1 Yes 2 No Specify: þ 3₽Widowed 4 □ Divorced i Hygiane, other than *natura ent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Olive Home Elementary/Secondary (0-12) College (1-4or 5+) HOUSELLIFE unknown permit. Pages 1 and 2 should be filed Department of Health and Mental Hygh Important. If Item 27 is marked other any Injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be MARY BURNES JAMES CHAMBLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doruthy WILSON / Daughter 3701 SequoiA AVE BOHINORS, Med 2121-20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cramation 3 Removal from Stata WOUDLAWN Cometry Wood Low, Mary los Donation 5 Othar (Specify) 22. Name and Address of Facility Cal ATMAN - HARRII KALYAI HUM- L 21. Signature of Funeral Service Licensee 240 REISTERSTOND RUDO Lynn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, ahock, or heart tailura. List only one cause on each line. Haus Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final INFARCTI disease or condition resulting in death) Examiner Physician/Medical Examiner DMGESTIVE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. the Due to (or as a consequenca of): 88 esn. signed by the a Part II. Other algorithma conditions contributing to death but not resulting in the underlying cause given in Part I, 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 45 Unknown Completed by 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 M No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 200 No 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 5 Pending invastigation 1 Natural 2 Accident 1 Yes 2 No death. the within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier completely (Check only one) To the

Registrar **DHMH 16 Rev 6/95**

State

29b. Signature and title of certifier

JYORTH WEST

multa

HOSPIT DEL

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 10 61 NOER P

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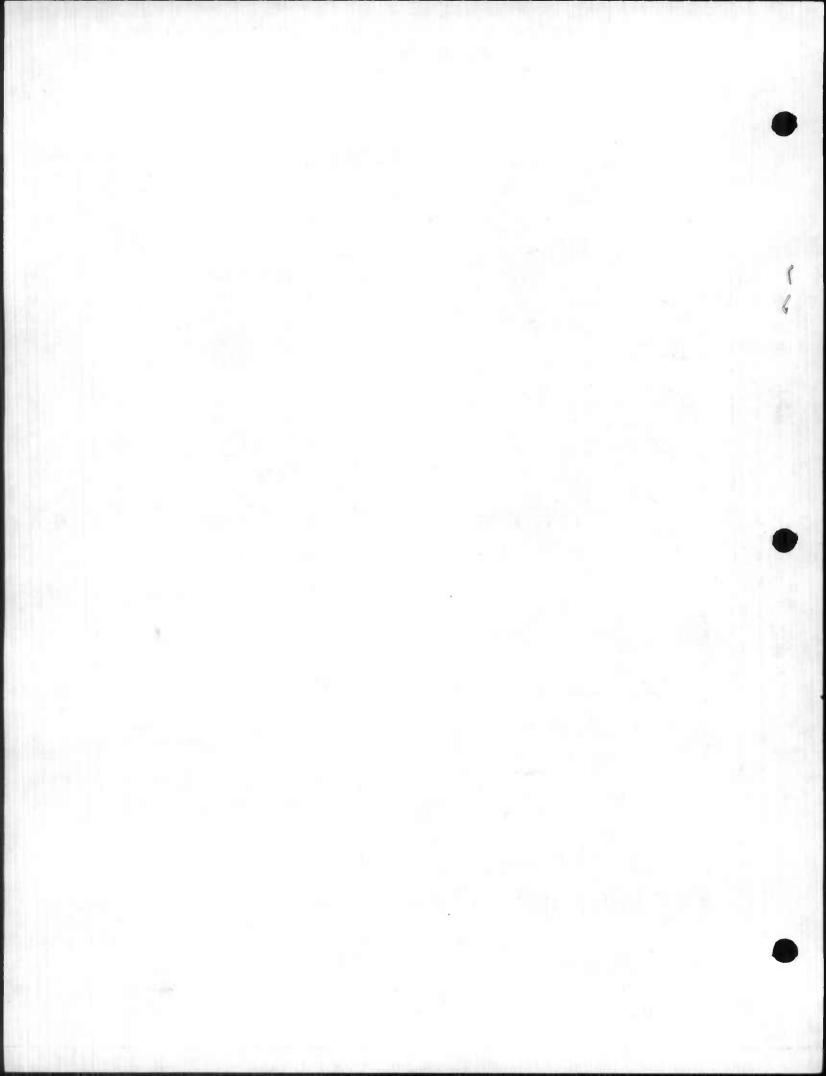
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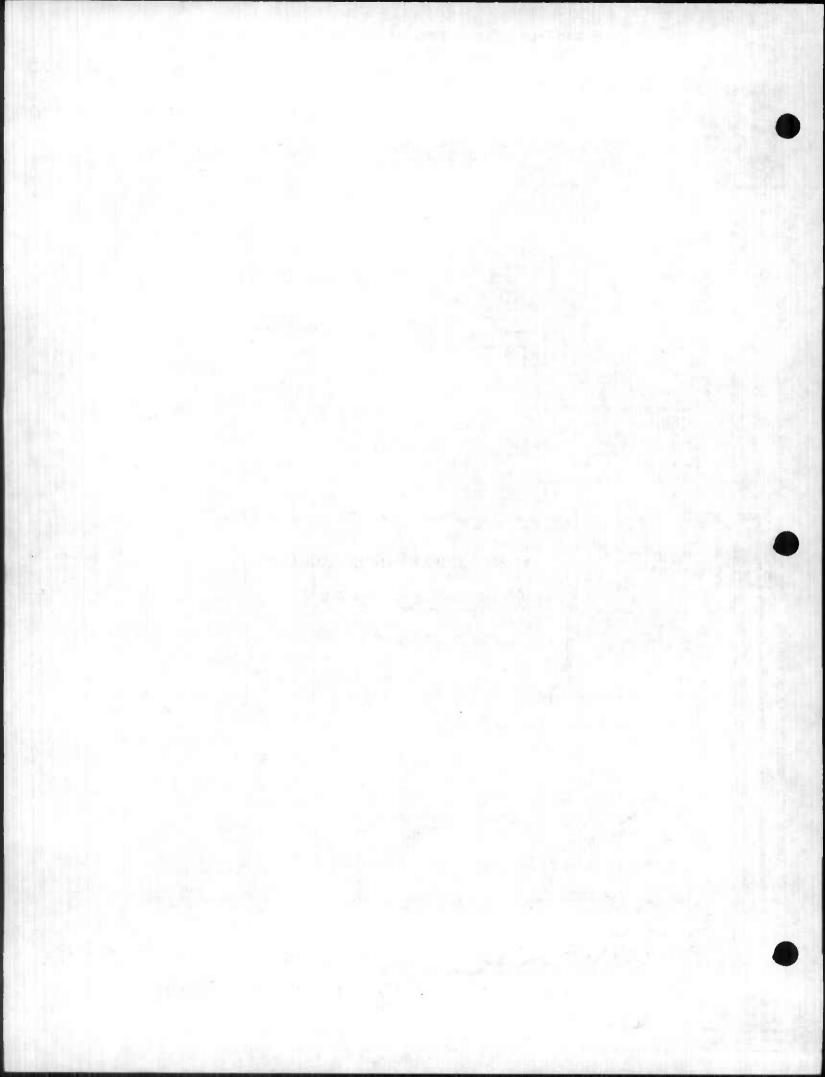
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29d. Date aigned (Month, Dey, Year)



			State of Marylar			of Health		lygiene Reg. No.	00	26349
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	ther death or them 23 siner must Funeral	11. Meritel Stetus	12. Wes Decedent Ever in U	,S. 13. 1	Wes Deceder	nt of Hispenic Or	igin? (Specify Yes or n, Puerto Rican, etc.)	No- 14.1	Race - America	
21215-0020	if, or he tramine		Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		t Yes, specify 1 ☐ Yes 💥				Bleck, White, e	
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Ξ	or At after Direction by	4 ☐ Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	ome, term, str fy)	reet, tectory, o	опісе	City or	Town, State)	Jili Der Or Hurai	House Number,
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	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29e. Certifier (Check only one) 2 Medical Exa	hystotan: To the best of my kno miner: On the basis of examine and menner steted.	etion and/or in	h occurred et vestigetion, in	the time, date en my opinion, de	nd plece, end due to eth occurred et the tir	the ceuse(s) and me, date and pla	ce, and due to	ated. the cause(s)
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		PINA	SM S		0	53330		Aubu	8T 16	2000
	0	30. Neme and address of person who		m 23a) (Type,	Print)					
	~	William Wysel, 1	My 600 Nº MX	nes s	851 B	Actimos	s rgmi)	21286		
	State	31. Dete filed (Month, Day, Year)	32. Registrart Sign	etur	Book	CO.				
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Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10) MAV5 /Medical 4b. City, Town, or Local on of Death 4c. County of Death 4a Facility Name (If not institution, giva street end number) Examiner 5 Windmill Chase, Apt. G Sparks Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yea Nov. 9,1919 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) 1□M 2\ F Months Days Hours Min. Yrs. 212-20-6834 80 Maryland Director Usual Residenca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Maryle 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinat, must be notified at 1 ☐ Yes 2 No Directo Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Windmill Chase, Apt. G 21152 USA Funeral 12. Was Decedent Evar in U,S. Armad Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: White Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Melden Sumema) 17. Father's Name (First, Middle, Last) Be George W. Black Ida Mealy 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 33 Sugar Tree Pl., Cockeysville, MD 21030 Dorothea McDonnell/daughter 20b. Place of Disposition (Neme of camatary, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial Gardens 8/14/00 Timonium, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Servica Licansee 22. Nama and Address of Facility Bryan W. Clary per DVR Lemon Funeral Home 10 W. Padonia Road, Timonium, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequenca of). and physician Physician/Medical the Due to (or as a consequence of): 98 950 ò ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Donknown signed b Division of Vital Records, by 24b. Were autopsy findinga availebla prior to completion of causa of death? 24a. Was an autopsy Completed peeu has page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No cartificate Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Homa 5 Aesidance 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftar 1 Waturat 5 Pending Hospital or Attending
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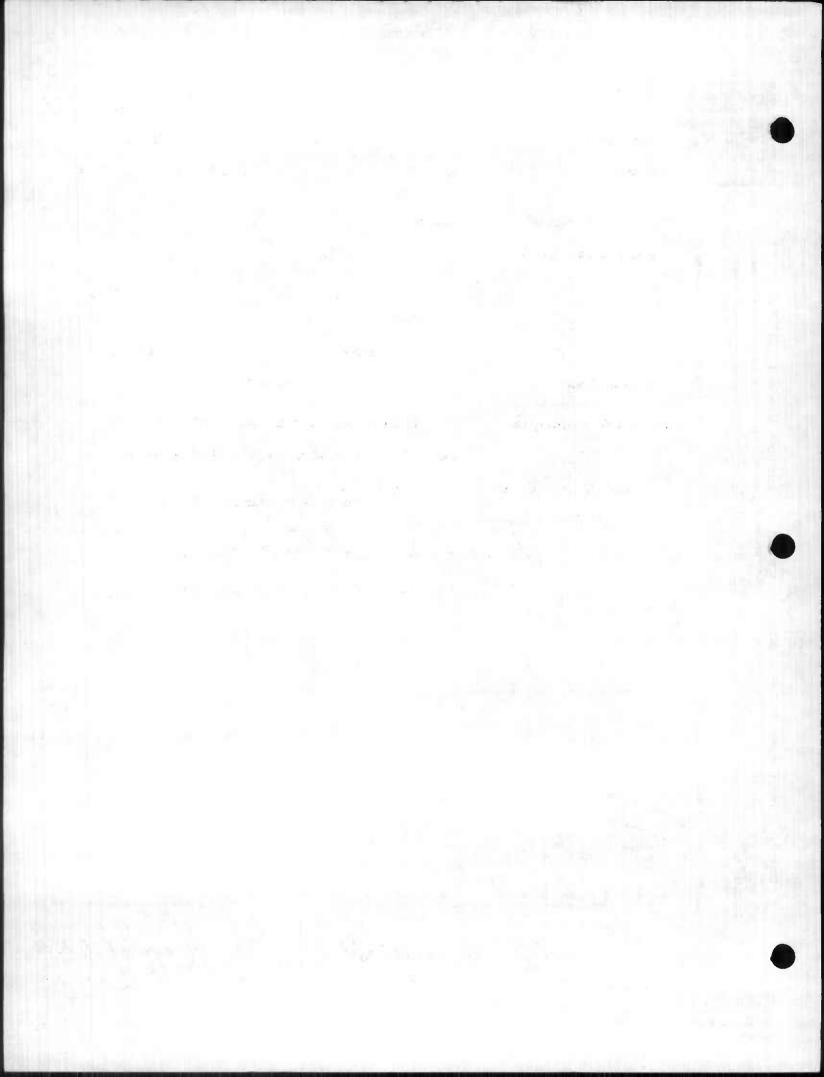
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier etely (Check only one) To the Vithin 2 To the Comple 29b. Signature and the of certifier 29d/ Data signed (Month, Dey, Year) License number

State Registrar AUG 2 1 2000 32. Registrar's

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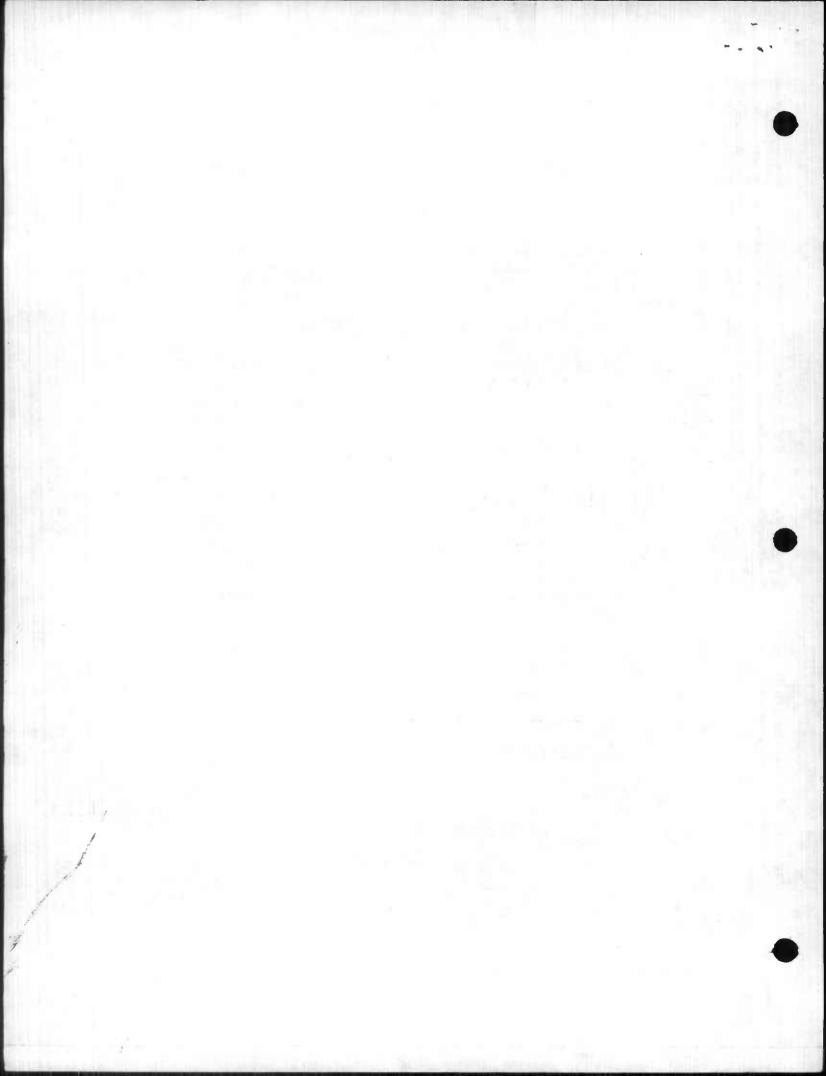
30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature



Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Pert III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Pert III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Pert III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Pert III. Other algnificant conditions contributia to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contributia to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contributia to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contributia to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contributia to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contributia to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contributia to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contributia to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contribute to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contribute to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contribute to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contribute to the causa of or available prior to completion of cause of death? Pert III. Other algnificant conditions contribute to the causa of or available prior to complet	Amended It	em#29d perPHYG786 8/21/		ryland / Depa <i>Ce</i>		of Health and of Death	d Mental Hy	giene Reg. No.	0 2635	1	
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	_ 5 00 J	examiner? 1 Yes 2 No	28a. Dete of Injury	28b. Time o		Other: 4 Nursin	g Home 5□ Res	idence 6 ZOth		1	
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30. Name entraddress of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrer's Signeture	811	David Ry	schors	301 5	Print)	pi B.	c grantli	1503			

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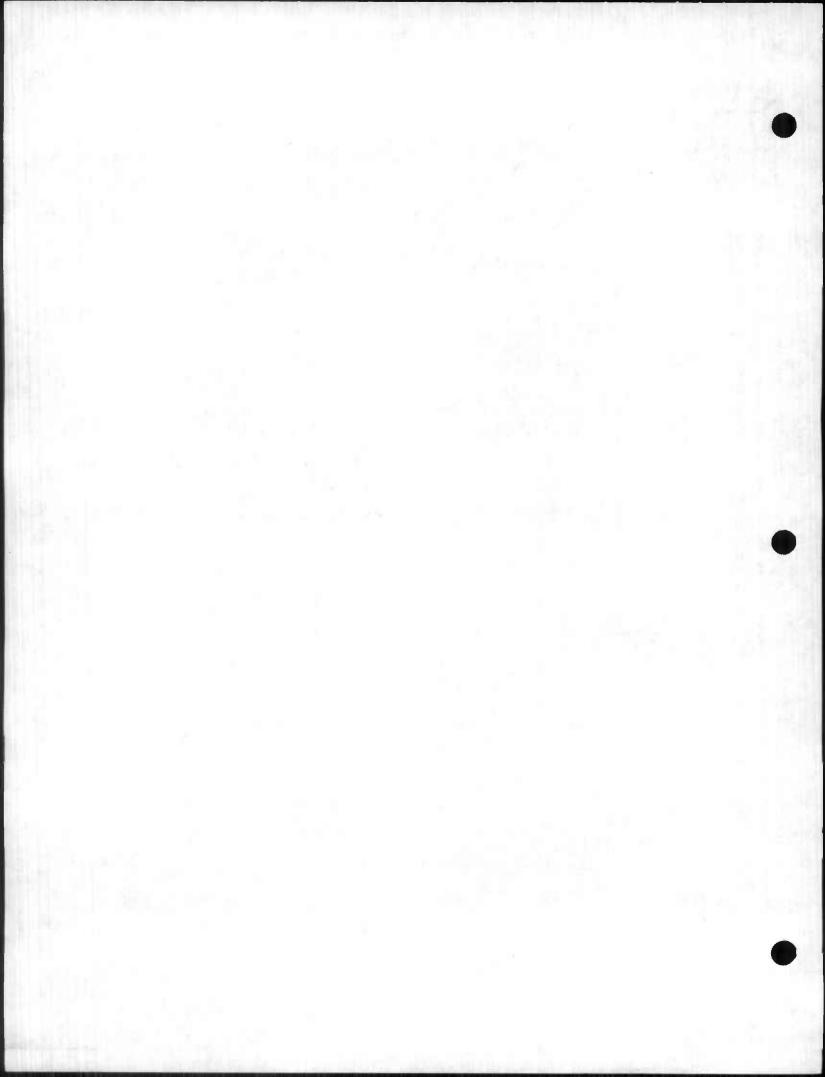


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	/Medic Examin	_	4a Facility Name (If not institution, give st	CONTRACTOR OF THE PARTY OF THE	7/00	4b. City, Town, or I	Location of Death	4c. County o				
30	Funeral Director		118-17-9034	M 20 F 7. Age (In yrs.	last birthday) If Und Month	er 1 Year If Under 24 Hrs.	8. Date of Birth Month, Day	Year, 1919	9. Birthplace (Sta	nte or Foreign		
	and ahow all ahow alfad at		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location	more			. /	le City Limits Yes 2 No		
	ith with the Mar 23s or 28s-f st ust be notified	Funeral Director	3800 W, R	eleved ere	are 101.2	21215	1	log. Citizen of W	hat Country?			
020	ors after dos	by	11. Marital Status 1 Never Married 2 Married 3 Widowed Divorced	2. Was Decedent Ever in U, Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		sedent of Hispanic Origin? (S secify Cuban, Mexicen, Puerl 2/S-No Specify:	pecify Yes or No- o Rican, etc.)		- American India c, White, etc.	ian		
21215-0020	d within 72 ho piene. r than "natur the Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12)		16a. Decedent's Us (Give kind of life. DO NO	vork done during most of wor	rking	16b. Kind of Bus	siness/Industry	cy		
yland	Mental Hy Mental Hy arked othe affic event,	To Be C	17. Father's Name (First, Middle, Last) William A	Denyins	Sv.	1 10	ne (First, Middle, Middle, Middle, Middle)	Surfar Surname)			
e, Mar	fand 2 sho feath and im 27 is me ther traum		49a. Informant's Name/Relationship (Typ 20a. Method of Disposition	tlem	19b. Meiling Addre	ss (Street and Number of Ri	Date	Otimo	Stete, Zip Code) Oity of Town, Stat	2/2/8		
Itimor	it. Pages itment of reant: if he njury or of		20a. Method of Disposition 10 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21 Signature of Theral Service Licenses	emoval from State	www.		8/23/00	arbu	tus, MU			
Ba	Depe Impo		Markell	Melle	LUM	y Turisil	tomey.	Balte	mal M	02/2/7		
	Physician		23a Part1. Enter the disease, or complic shock, or heart failure. List only one			ode til dying, så sk fartist ille	or respiratory an	nst.	Approx Interval Onset	imate I Between and Death		
	/Medical Examiner	7.5	Immediate Cause (Final disease or condition resulting in death) a.	ACUTE Due to (o	MYO CAR	nam INFAM	NOTE		1			
	uted d ansit	Examiner	b.		TAYE RE	VAL DUEAS	E					
68760,	physicis	edical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
Box	SE 00.00		d.									
P.O.	t the dea by the al	hysic	Part if. Other significant conditions control	ributing to death but not res	ulting in the underlying	g ceuse given in Part I.			tribute to the car			
ords, F	The law requires that the death certifiate has been signed by the attending page 2 should be detached for use as	Completed by Physician/M					24a. Was a	an autopsy med?	24b. Were euto available p completion	rior to .		
I Reco	The lay	Comple					10 4	es 2000	of deeth?	2 CNo		
Vita	clan: sertific ector,	Be	25. Was cese referred to medical examiner?	ospital:		Other:	ath (Check only o					
ō	Physic r this gral direction	. To	1 Yes 2 XNo	28a. Date of Injury	ER/Outpetient 3 28b. Time of	DOA 4LJ Nursing P	1ome 5 Resid	ience 6 Othe				
Division of Vital Records,	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certification between the funeral director, completely filled in by the funeral director.	Certification:	Naturel 5 Pending investigation Suicide 6 Could not be determined	(Month, Day Year) Injury Work? M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Number, City or Town, State)			Number,		
۵	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical Cer	29a. Cartifier 1 Certifying Physic (Check only 2 Medical Examin	cian: To the best of my kno	wledge, death occurre	ed at the time, date and plecton, in my opinion, deeth occ	a, end due to the o	cause(s) and ma		use(s)		
	thin 2 the symplet	D S	one) 29b. Signature and title of certifier	and manner stated.		29c. License number			I (Month, Day, Ye			
			16.E. Laline	MO		RES-un			17,205			
1	1		30. Name and address of person who con									
-	Stat	e	31. Date filed (Month Day Year) 1 21	32. Registrar's Signa	ature &	South						

DHMH 16 Rev 6/95

PATIENT KNOW A DORDING JEWICING



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Year Month Marsha Klash August 18 0608 2000 4a Facility Name (If not institution, give street and number) Tohns Hopkins Bayview Emergency Room Baltimore Tohns Hopkins Bayview Emergency Room Baltimore 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 4, 1917 4a Facility Name (If not institution, give street and number) 4c. County of Deeth N/A 5. Social Security Number 9. Birthplace (State or Foreign Country) Ohio Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d Inside City Limits Yes 2 No Maryland Baltimore City Baltimore 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 1401 North Lakewood Avenue, Apt 204 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1□ Yes 2□ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) State of Maryland Bookkeeper 2 yrs 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) John Klask Anna Falotko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Betty A. Veloz (Sister) 8423 Cocoa Road, Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 8/21/2000 Parkville, Maryland 21. Signature of Funerel Service Licensee Robert C. Altenburg 22 Name and Address of Fecility Altenburg Funeral Home, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final Myocardial Infarction disease or condition resulting in death) hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events Due to (or as e consequence of): that initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 → Unknown 1 Yea 2 No 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ENatural 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Examiner physician and the burlei-traneit The law requires that the death certificate be executed P.O. Box 68760. Physician/Medical ettending ph signed by the et id be deteched for Division of Vital Records. Completed by Dege 2 or Attending Physician: Be 2 After this funeral Certification: deeth. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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r 28a-f

8 iner must be

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72 hours after

Pages 1 and 2 should be fliad within 72 hours aft nent of Health and Mental Physics.

Intil If term 27 is marked other than "naturel", or with If term 27 is marked other than "naturel", or usy or other traumatic event, the Medical Example.

Physician /Medical

Examine

Baltimore, Maryland 21215-0020

Using Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53124 August 18, 2000 mmy Elmond MD

Jimmy Edmond M.D.

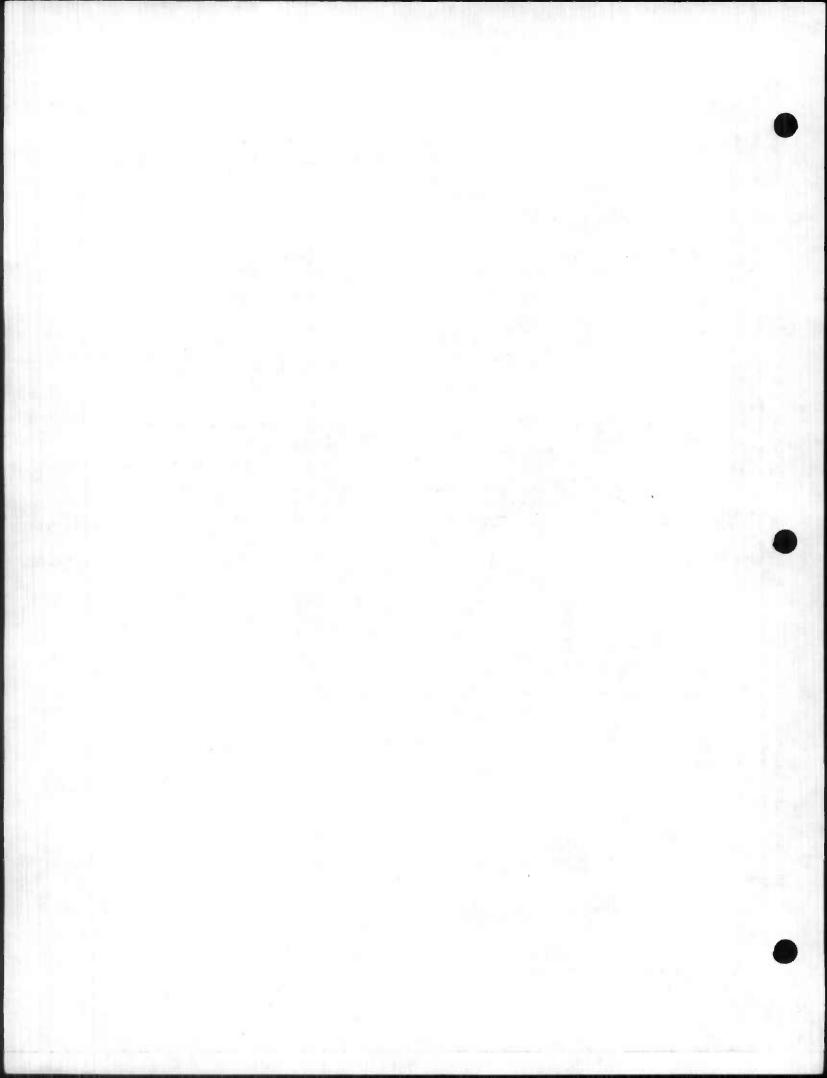
State Registrar

31. Date filed (Month, Day, Year) AUG 2 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4940 Eastern Ave, Baltimore, maryland oaks



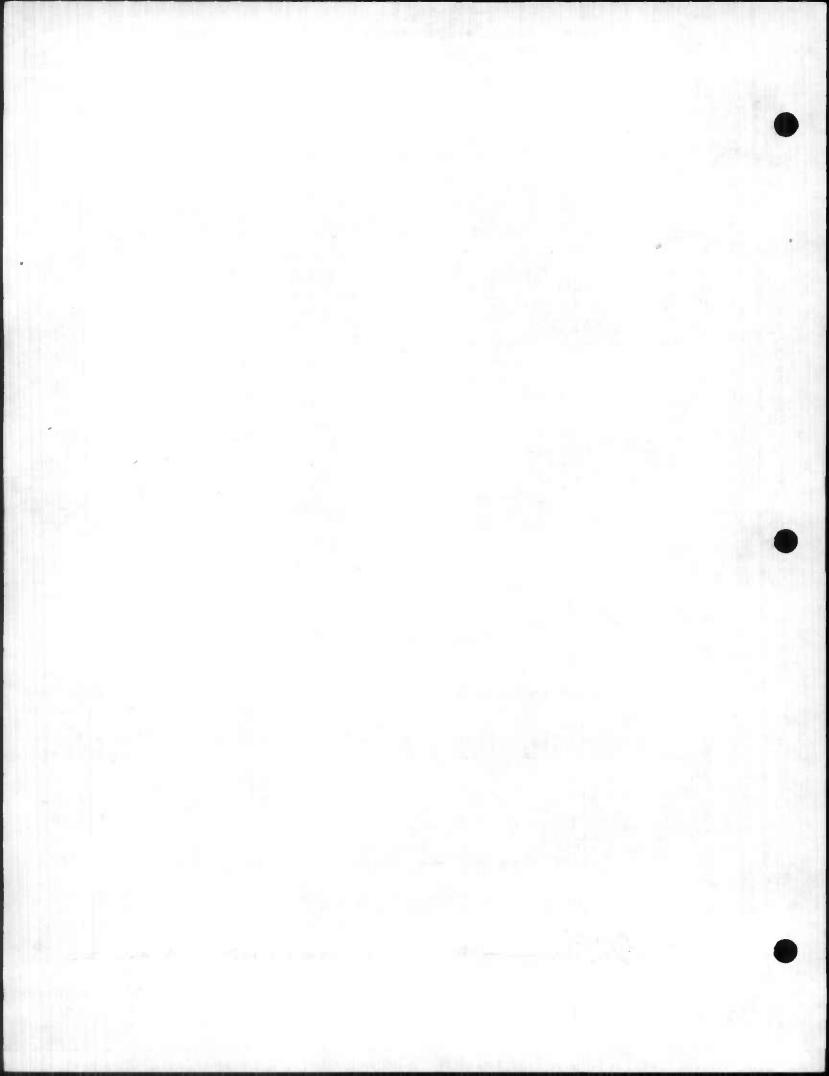
State of Maryland / Department of Health and Mental Hygiene 26354 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 16, 3:00 pm Tatsuko Kenealv AUG. 2000 /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Elkridge 7246 Montgomery Rd., B Howard Apt. 8. Date of Birth (Month, Day, Year) MAR . 31, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 212-46-5411 Yrs. 72 1928 Director Japan **Usual Residence of Decedent** the Menyland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Elkridge MD Howard 1 ☐ Yas 2 No Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 USA 7246 Montgomery Rd., Apt. B "natural", or items 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer and of Health and Merials Hygiene.

THE 18 mar 27 is marked other than "natural; or fleating or other treumatic event, ins second 1 ☐ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Ves 2 DNo Specify: Specify: Asian P 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sisters of Trinity 6 Caretaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shizu (Unavailable) Matuzero Okuno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Kenealy, Jr.-son | 1452 B. Washington Ave., Severn, MD 21114 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Report 4 Donation 5 Other (Specify) eval from State permit. Page Department of Important: If eny Injury or page. Chesapeake Crematory 8/20 Beltsville, Md. 22. Name and Address of Facility of Fungral Service Lice Gary L. Kaufman Funeral Home 1775 7250 Washington Blvd., Elkridge, MD 21075 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final End Stage COPD disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner Abdominal Aortic Aneurysm law requires that the death certificate be executed ettending physician and I for use as the buriel-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Records, ò 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 Netural 5 Pending investigation death. 1 Yes 2 No To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completaly filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide W Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) - MD (DE) 201 25 CIM 18 AUG 2000 30. Name and artifress of person who completed cause of death (Item 23a) (Type, Print) Balto., Md. Nevins Johns Hopkins University - Meyer Bldg. 7th Flr. 31. Date filed (Month, Day, Year) AUG 2 1 32. Registrar's Signature State 2000 Mayer

DHMH 16 Ray 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Year **Physician** JACK RICH KINNEY 8.22 Am 08 17 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ADMINIS TRATION BALTIMORE BALTIMORE VETERANS Hours Min. 8. Date of Birth (Month, Day, Year)
MAY 22, 1 7. Age (In yrs. last birthday) If Under 1 Year Months Deys 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country)
Virginia **Funeral** Deys 1₩ 2□ F 267-56-7560 61 1939 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Eidson 1 Yes 2 No Director TIM Hancock 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 6 37731 Rt. 1, Box 213B USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Merital Status 72 hours after 1 Ves 2 No If Yes, Give Year or Dates: 1 Never Married 20 Merried 21215-0020 8 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Armed Forces Soldier Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H ant: if Item 27 is marked oth lury or other traumatic even Be Katherene Ledford Roy James Kinney 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Sharon Kinney - wife Rt. 1, Box 213B, Eidson, TN 37731 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/22 Castle Cemetery Eidson, Tenn. 21. Signature of Funeral Service Licens 22. Neme and Address of Facility Gary L. Kaufman Funeral Home elens 7250 Washington Blvd.

desaud or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory failure. Ust only one cause on each line. Elkridge, Md. 21075 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical SEPSIS 24 4/5 Examiner Due to (or as a consequence of): Examiner PNEUMONIA 5 WEEK The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence ot): Box 68760, Physician/Medical Due to (or as a consequence of): for use as the Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 12 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY DISEASE Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; 25. Wes case referred to medicat examiner?

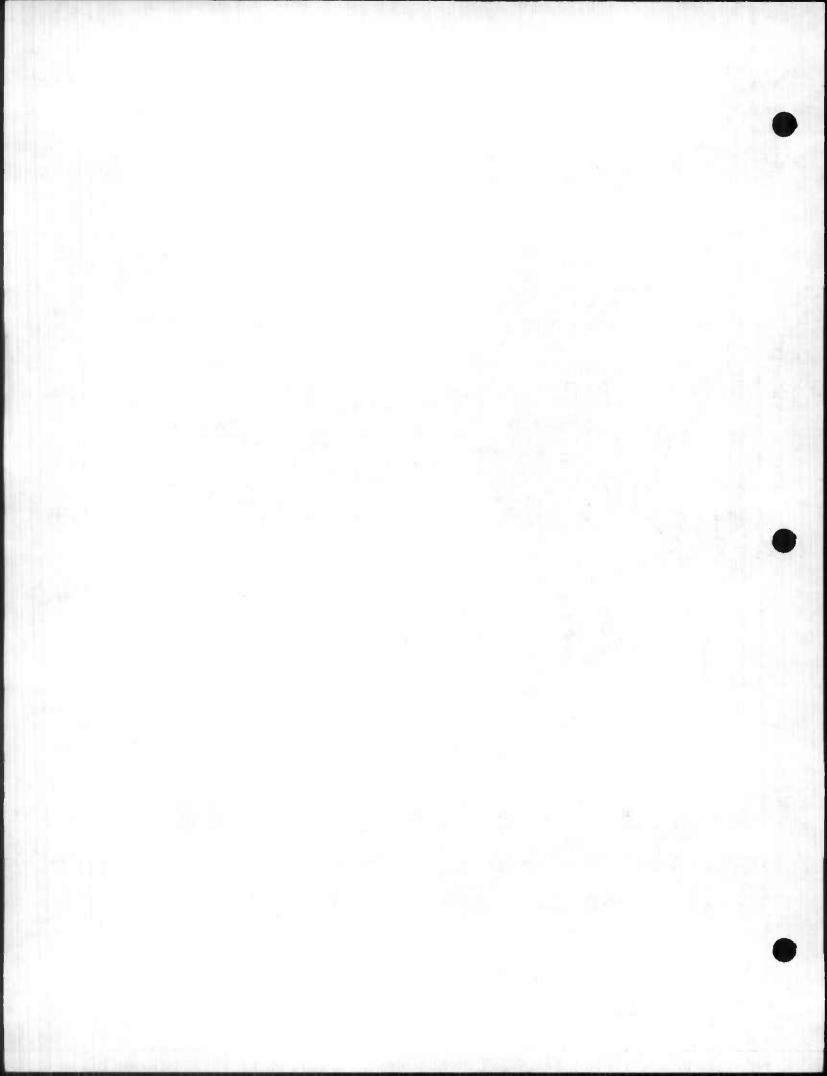
1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospital: 1 Denpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) P12 463 Lourden 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. GREENE ST, BARDHONE MD. 2120° Osei Boatena Lwabeng

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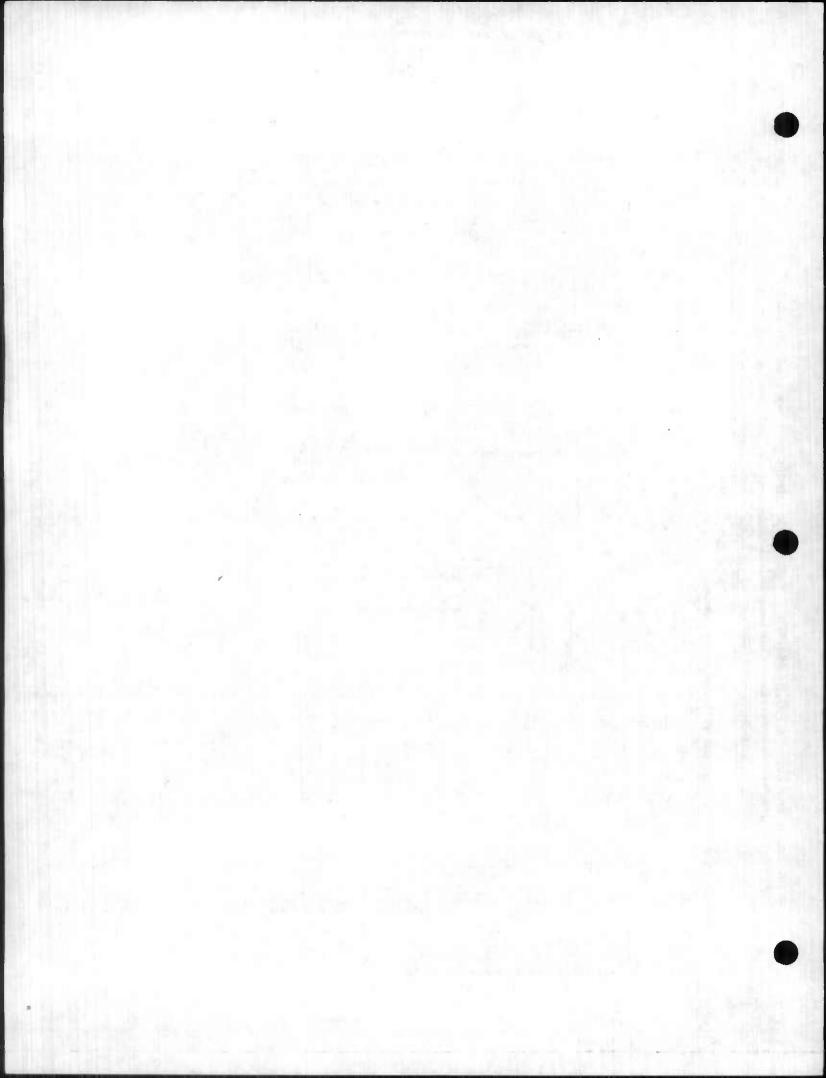
State Registrar 32. Registrer's Signature

G 2 1 2000



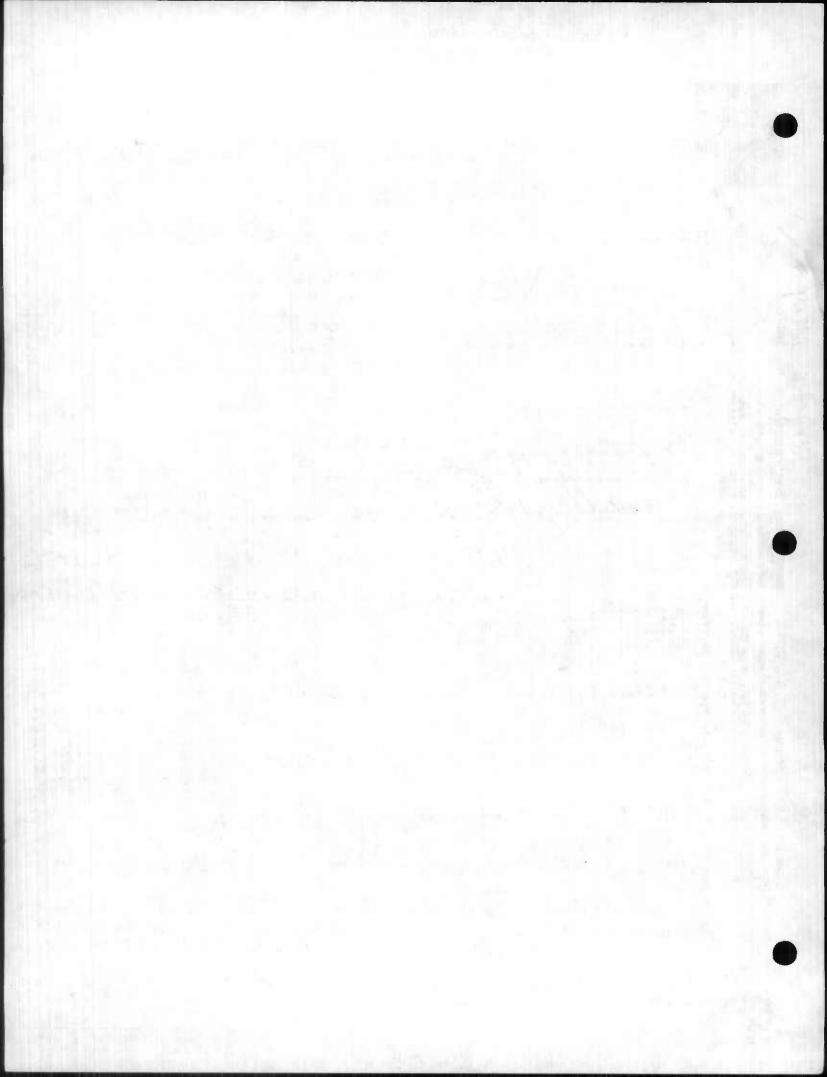
State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg.	No.	20336
Physician	1. Decedent's Neme (First, Middle, Last) 2.	Dete of Death Month	Day Year	3. Time of Deeth
/ /Medical	DITTION MOTTE VETTER	ugust 1	16,2000	8:20 am
Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Local	tion of Death	4c. County of Dee	
	Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	Anne A	
Funeral Director	Months Devs Hours Min.	(Month, Day, Yeeb. 18, 1	914 Mai	rthplaca (State or Foreign country) ryland
Man Man Man Man Man Man Man Man Man Man	10a. State 10b. County 10c. City, Town or Location		711-513	10d. Inside City Limits
a Mar illiad otor	MD Anne Arundel Severna Park			1 ☐ Yes ACNO
of the Ma	10e. Sfreet and Number 10f. Zip Code	10g.	Citizen of Whet C	ountry?
4 6 m	503 Owens Way 21146		S.A.	
Z I Z I D-UUZU d within 72 hours after death with the Maryla pere. The Medical Examiner must be notified at completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Rich Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Rich Yes, Give Year or Dates:	ly Yes or No- can, etc.)	14. Reca - Am Bleck, Whi	
Fig. 10 Oct.	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b	. Kind of Business	s/Industry
The same of the sa	Elementary/Secondary (0-12) College (1-4or 5+)			
	4 Supervisor		.M. Pit	its
E STOR O	17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Last)			
To To	William Kelley Dara M 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F	iontgom	-	Zin Code)
Md 2s				
than 2	20e Method of Disposition 20b, Placa of Disposition (Name of		Location - City o	
o dina	1 X Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Cemetery, crematory or other place) Meadowridge Mem. Pk. 8	/18 E1	kridge	MD
pamil. Pages 1 a Department of He Important if then sny injury or othe	22. Neme end Address of Fecility ary @ Meadowridge Mem Elkridge Mary 23e. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or stock, or heart feilure. List only one cause on each line.	L. Kau Park Yland espiratory errest,	fman Fu 7250 Wa 21075	Approximate Intervel Between Onset and Deeth
Physician /Medical Examiner	Immediate Ceusa (Final disease or condition resulting in death) a. Due to (or es e consequence of): Oring by that I infection			
both conflicts be associed asteroid physician and for use as the bunal-transit clary. Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
death certain death certain death certain death certain death certain death certain death	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobac	cco use contribu	te to the cause of death?
uires that the deeth certification is signed by the attending id be detached for use a by Physiclan/M	hypercalcemia, hyperkalemia, acute			Probably 4 Unknown
raquir should eted	renal feilure, CHF	24s. Wes en e performed		. Were autopsy findings available prior to completion of cause of death?
The law tie has page 2:		1 ☐ Yas	2 No	1 ☐ Yas 2 ☐ No
	25. Wes case referred to medical 26. Place of Death (Check only one)		
Physician: rthis certific ral director,	exeminer? 1 Yes 2 No Hospital: Yanpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	a 8 Other (Sp	ecity)
Ing Pt Wher th Where the	1 Naturel 5 Pending (Month, Day Year) Injury Work?	d. Describe how i	injury occurred	
to a standing Physical or at all Director: After this of the funeral director: After this of the funeral director: To Certification: To	2 Accident Investigation Investigation M 1 Yes 2 No 3 Suicide 4 Homicide M 1 Yes 2 No 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f	f. Location (Stree City or Town, S		Rural Route Number,
n 24 hour n 24 hour n 24 hour n Funer pletely fill edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred and menner stated.	d due to the caus et the time, date	e(s) and menner a end place, and di	as stated. ue to the cause(s)
Within to the compound of the the the the the the the the the the	29b. Signature and tille of certifier 29c. License number		Date signed (Mor	
J	D41816		8/16/	2000
OB"	30. Name and address of person who completed cause of peath (Item 23e) (Type, Print) Charles W. Phelps MD Anne Avandel Medical Center	64 F Ann	=vanklin	St. M.D. 2140
State	31. Date filed (Month, Day, Year) 32. Registrar's Signeture		,	



State of Maryland / Department of Health and Mental Hygiene 00 2635

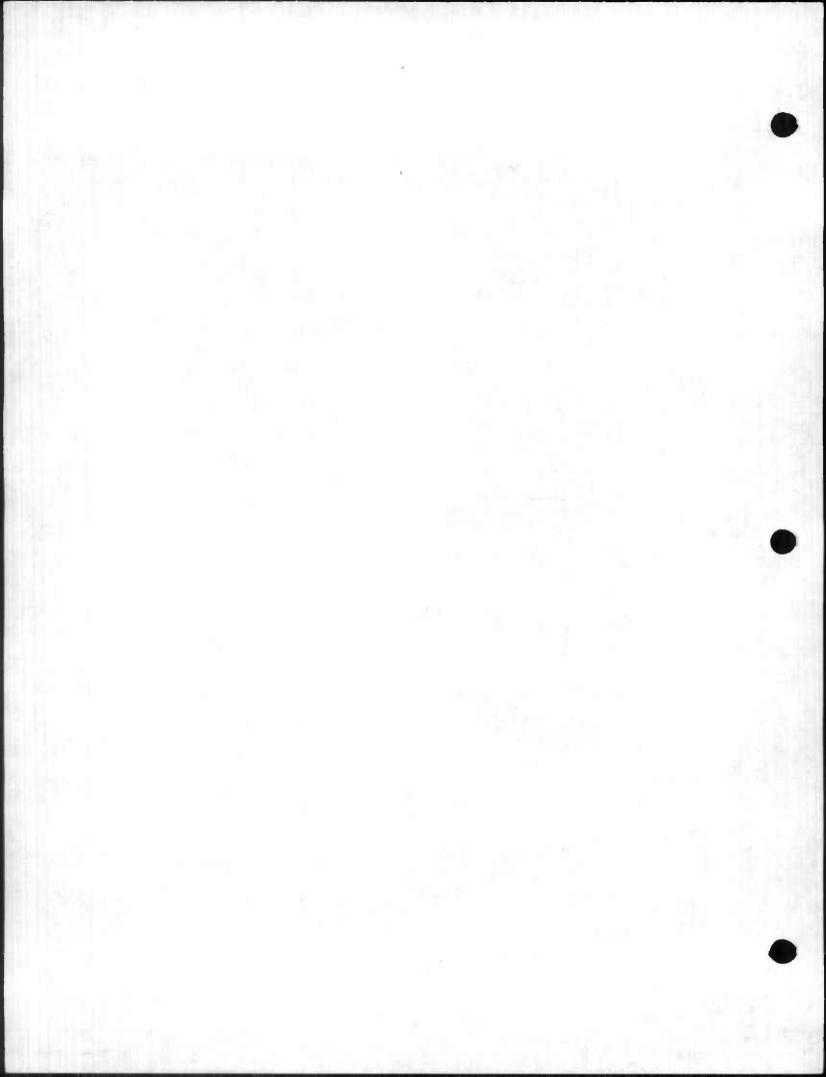
			Cer	tificate	of Death		Reg. No.	0 4	.000
	1. Decedent's Nama (First, Middle, La	st)				2. Dete	of Deeth h Dey	Year	3. Time of Deal
Physician /Medical	Mary France	s Koryck	i			Augu	1 10 7	2000	4:15
Examiner	4e Facility Name (If not institution, give				4b. City, Tov	vn, or Location of		of Death	
	North Arundel	Hospital				Burnie	Anne,	Aruna	del
Funeral		Sex 7. Age (In yrs	75 Yrs.	If Under 1 Months	Yeer If Under 2 Days Hours	Min. 8. Data	of Birth	9. Birthpla Country	ce (State or For
Director	232-30-7928		/J Hs.			June	27, 1925	North	Caroli
1.	Usual Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Loc	cation	***			100	d. Inside City Lir
and an	A		on Divino						1 ☐ Yes 2 🖔
28a notifi	Maryland Anne Ar	under	en Burn	10f. Zip C	Code		10a. Citizen of V	What Countr	v?
I Dir	6664 Robert Court				21061		USA	4	
man 2	11. Merital Status	12. Wes Decedent Ever in	U,S. 13. V		onf of Hispanic Original Cuban, Mexican	gin? (Specify Yes	or No- 14. Rac	a - America	
r. or he	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Yes, specif		, Puerto Rican, et		ck, White, et /: Whit	
ted to	15. Decedent's E	ducation	16a. Deced	lent's Usual	Occupation	at waters	16b. Kind of Bu	usiness/Indu	stry
youne, her then 'natur it, the Medical Completed	(Specify only highest gra Elementery/Secondary (0-12)	College (1-4or 5+)	life. E	OO NOT use	done during most retired)	or working			
the con	11		Ho	memake				ouseho	ld
avent Went	17. Fether's Name (First, Middle, Last				18. Mothe	r's Neme (First, A	diddle, Maiden Sumaπ	19)	
To I	Jesse Mann				Ar	nnie Mai	ude Hawkir	าร	
DUB III	19a. Informant's Name/Reletionship (Vumber, City or Town,	State, Zip C	Code)
n 27	Beverly Rochford						, MD 21122		
9 9 9	20a. Method of Disposition		Place of Dispos cemetery, crem	sition (Name natory or oth	e of ner place)	Date	20c. Location -	City or Tow	m, State
2 2	4 □ Donation 5 □ Other (Special		ryland	Vetera	ans Cem.		22 Crowns		
Though a	21. Signature of Funeral Service Lice	nsee			Address of Fecilit		ings Funera		
8 2 2 2	Mush (1)	1/4/1/	1. 1				asadena, Mi	2112	22
	23a. Part/. Enter the disease, or com shock, or heart failure. List only	plications that cause !!!	In Do not ente	er the mode	of dying, such as	cardiac or respira	tory arrest,	1	Approximete Interval Betwee
Medical caminer	Immediata Cause (Finel disease or condition resulting in death)	a. PNEU	(or as e conseq	VI)	9			1	DA
ě					PUCT	TVE	ATOLI	SVE	INYE
in and ial-transit Examiner	Sequentially list conditions.	b. Due to	(or as a conseq	uence of):	100/	DT	25000	113	10 11-
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury. b. CHRONTC OBSTRUCTIVE AIRWA Due to (or as a consequence of): Cause, Diseases or injury c.								
physicle s the bu	thef initieted events resulting in death) Last	C. Due to (or as a consequ	uenca of):				1	
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for use		d							
gned by the attend be deteched for us by Physician/	Part II. Other algolificant conditions of	ontributing to death but not re	sulting in the ur	nderlying ca	use given in Part I	. 231	. Did tobacco usa co	ntributa to	the cause of d
deteched deteched							1 ☐ Yaa 2 ☐ No	3 Probe	ably 4 Uni
signed I d be det			1					<u> </u>	
page 2 should Completed						248	. Was an autopsy performed?	avai	a autopsy findir ilable prior to
2 sh									pletion of causeath?
page Com							1□ Yes 21 No	10	Yes 20 No
certificate has rector, page 2 Be Comp	25. Was case referred to medical				26. Place	of Death (Check	only one)	1	
10 D	examiner?	Hospital: 154npatient 2[☐ ER/Outpatien	1 3 DOA	Other: 4 Nu	rsing Home 5	Residenca 8 Oth	ner (Specify,)
63	27. Manner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28	c. Injury at Work?	28d. Des	cribe how Injury occur	rred	
ctor: Aft y the fur Ilcatio	2 Accident investigation	n	1-7	M	1 Yes 2	No			
Director d in by the	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At building, etc. (Spec	home, farm, stri	eet, factory,	offica	28f. Loca City	ition (Street and Numb or Town, State)	ber or Rural	Route Number,
rs after death. al Director: After t led in by the funers Certification:		3, 5,5,5							
uner by fill		yalcian: To the best of my kr niner: On the basis of examin							
Within 24 hours a To the Funeral E completely filled Medical Ce	one) 2 Madical Exam	and manner stated.	enon and/or inv	restigation, I	ят ну ориноп, ова	un occumed at the	time, date and piace,	=10 000 10	ing carea(s)
within 24 hours at To the Funeral I completely filled	29b. Signeture and fitte of certifier	~ B~ 1		29c.	License number	11	29d. Date signe	ed (Month, D	Day, Year)
Y		M() Start	n.D		0516	64	110903	/ /	7 20
0	30. Name and address of person who	completed cause of death (tte	om 23a) (Type,	Print), 50	DHIR	Kum	AR, AGG	ARI	VAL
De	30. Name and address of person who NORTH ARUND	EL HUSPIT	AL, 30	HO	PITAL	PRIVE	GLENT	13 VRI	VIE,
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	E	local.	1			211
Registrar	MIC 9	2000 b /24m	was	D)	Ligi ardis				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26358 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:00 PM Ruth, Levickas 2000 August dMedical dical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Baltimore St. Elizabeth Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Yrs 214-56-8881 86 Director 03/25/1914 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 228 2200 Pleasantville Avenue 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "naturel", or items 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yaar or Datas: 1□ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Mental Pe Harry Brickerd Mary J. Voracck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If Nem 27 2906 Ebbwood Drive, Ellicott City MD 21042

ce of Disposition (Name of Date 20c. Location - City or Town, State Mary Carol Davis Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages nant of 1 Buriai 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Holy Redeemer Cemetery 8/21/00 Baltimore, Maryland Sterling-Ashton-Schwab Funeral Home, Inc. 21. Signature of Funeral Service Licensee 736 Edmondson Avenue, Catonsville, Maryland 21228 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disaasa or condition resulting in death) nille**ar**ea carcinoma to peritoneum 6 month Examiner Due to (or as a consequence of): Examir siclan and bunal-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca ot): the attending physician hed for use as the buna Box 68760 **Physician/Medical** Dua to (or as a consequença of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown obstructive nulmonary by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed performed' 1□ Yes 2DNo 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how Injury occurred if or Attending F after death. I Director: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C 1/C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0055391 August MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisterstown, Maryland MINGYI 210 Business Center Drive AUG 2 I 2000 32. Registrar's Signature Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 12:50 P.H Aug 18 2000 4b. City, Town, or Location of Death lity Name (If not institution, give street and number) 4c. County of Death Ag Baltimore tal 405 If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of 9. Birthplace (Stelle or Foreign 7. Age (In yrs., last birthday) Min. Months Days Hours 100 M 20 F Yrs. 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No 10g. Citizen of What Country? et and Numbe 10f. Zip Code mal d/d/0 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2DNo Black Specify Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) 2820 20b. Place of Disposition (Name of cometery, cramatory or other p. MD. National / 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Defemation 3 Removal from State 4 □ Donation S Other (Specify) 21. Signature of Futural S Approximate Interval Between Onset and Death tisease or comp railure. List only o plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease of condition resulting in death) · INTRACRANIAI BLEED 24 hrs. Dua to (or as a consequence of): VNUMOUN ALZIY色IMIOn's DISEASE CONVULSIVE UNICHOUN DISONDER Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician/Medicai Examiner

Medical Certification: To Be Completed by

25. W

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f ahon

the Medical Examiner must be notified at

6

"netural".

Il Hygiene.

.. Pages 1 and 2 should be fill thent of Heelth end Mental H tant: If Itam 27 la merked od

pemil. Pages 1 and 2 is Department of Heelth er Important: If Itam 27 is any Injury or other trau pncs.

filed within 72 hours effer death

Baitimore, Maryland 21215-0020

NAME CLCLY 1 H IB に B IB に Box 68760, Division of Vital Records, P.O. Box 68760,

Director

Funeral

þ

Be Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No 1 ☐ Yes 2 XNo

as case referred to medical	26. Place of Death (Check only one)							
aminer? Yes 2 No	Hospital:	2 ☐ ER/Outpatient	3□ DOA	Other: 4 Nursing Home	5 Residence	8 Other (Specify)		

27. Manner of Death Natural 2 Accident

3 Suicide

29a. Certifie

4 Homicide

5 Pending investigation 6 Could not be LPXII. 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes 2 No 28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date aigned (Month, Day, Year)

H.D

P125 32

AUGUST 18, 2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

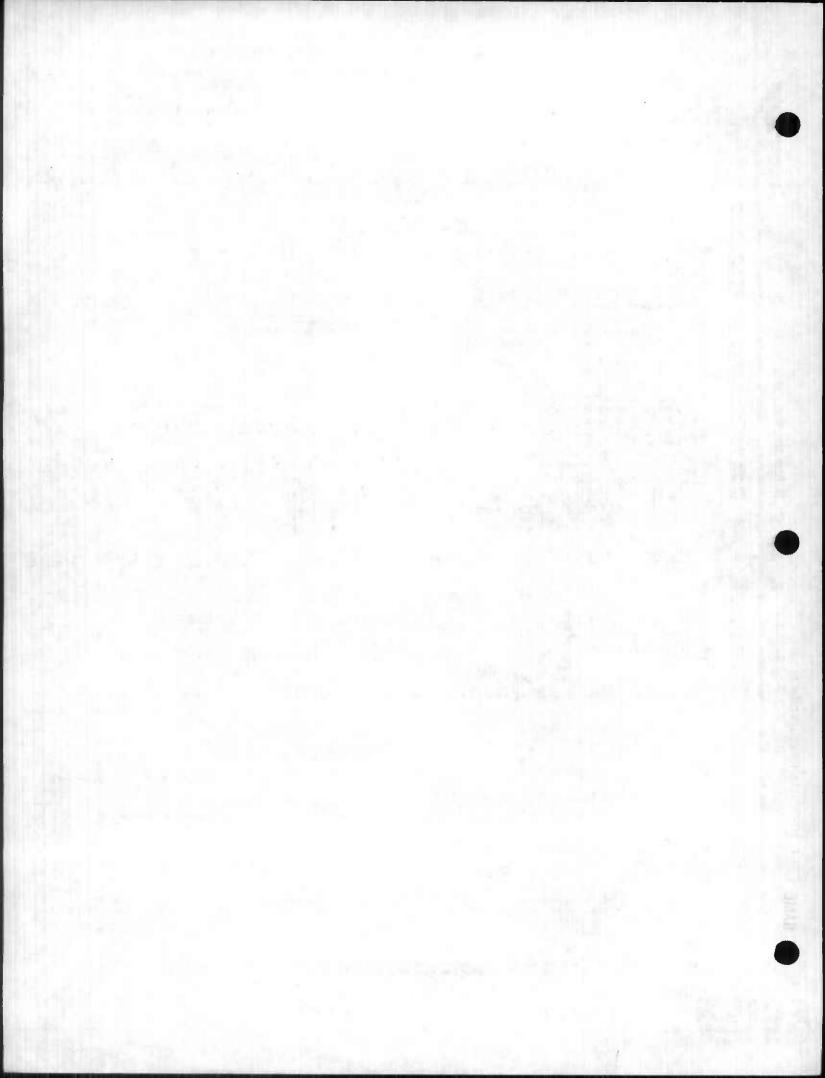
SOD CATON AUR, BALLIMONE, MD LIAN 1131 MAKSY MI KAWA

31. Date filed (Month, Day 32. Registrar's Signature

State Registrar

Director:

within 24 hours a



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended items# 4a&24a per FH G787 9-6-00 WJJ Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physiclan** OWERY 4b. City, Town, or Location of Death osumary 19 2000 /Medical 4c. County of Death 4a Facility Name (If not Institution, give street and number) Shore Home Care Examiner ORIUS Hospice Talbot EASTON HUMDO If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) ff Under 1 Year 7. Age (In yrs. lest birthday) 5. Sociel Security Number 6 Sax Birthplace (State or Foreign Country) **Funeral** 1 M 2 P Months Days 178-32-9919 84 26, 1916 Director Feb. PA Usual Residence of Deceden with the Merylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Talbot Oxford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 218B North Morris Street 21654 U.S.A. Funeral death 14. Race - American indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumetic event, the Medical Exercises 2008. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryiand 21215-0020 1 Yes 2 No Specify: Specify: White ٥ م 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Joseph Leo Galen Mane Marie Kerr 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fiona Foster/daughter 102 East Street, Oxford, MD 21654 Baitimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Ronald S .Wade Director State Anatomy Board, 655 W. Baltimore Street DUR Haltimore, MD 21201

Arti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ack, or heart failure. List only one cause on each line. Baltimore, MD 21201 interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS THAUIMINT Examiner OWER Extremit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last er phers 050 Physician/Medical Due to (or es e consequence of) 88 CEREBROUNSCULAR INSUFFICIENC use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting In the underlying ceuse given in Part I. 3 □ Probably 4 Unknown 3 1 Yes 2 No 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ¥ Yes 2 □ No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicel exeminer? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Dother (Specify) HOSPITE Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dey Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 8 Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. (Check only one) the the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print)

32. Redistrar's Signature

2540 Centreville Road, Centreville, MD

2

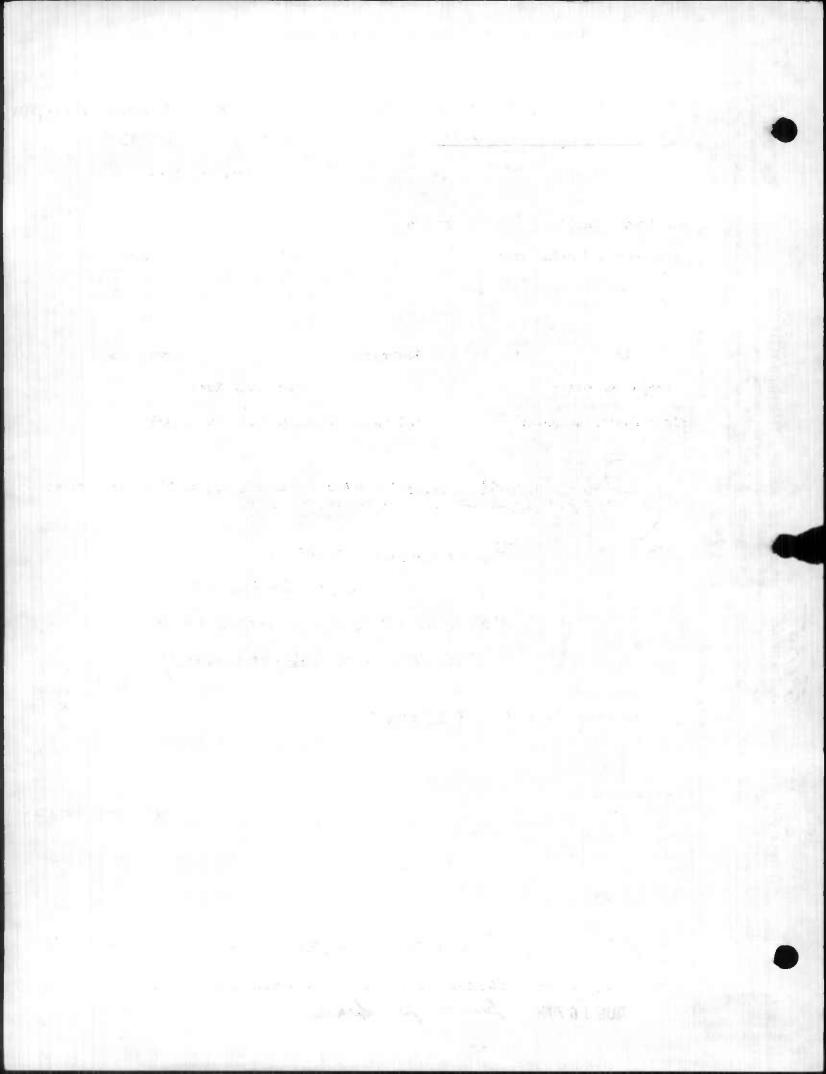
21617

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

Eric Cidarek, MD

AUG 1 6 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LANNEN **Physician** 2:37 AM August 2000 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner ter to.S ware a 10 IMore bitai If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 6. Sex **Funeral** Days Hours Min 1₩ M 2□ F 59 217-38-5715 Director Pennsylvania Feb. 6, 1941 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes Ž ☐ No Directo Dundalk 28a-f Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or must be 21222 2058 Jasmine Road United States Funeral Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried b 1 ☐ Yes 2 ☑ No Specify: White Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ring most of working Elementary/Secondery (0-12) College (1-4or 5+) Trucking Industry 9 Years Truck Driver 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Floyd To Lannen Sarah Love 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Sally R. Lannen (Wife) 2058 Jasmine Road Dundalk, Maryland 21222 If Ham 27 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremetion 3 ☐ Removel from State Hilltop Service Corp. 8/18/2000 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funerel Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final leare disease or condition resulting in death) Examiner Examine The law requires that the deeth certificate be executed es the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequenca of): the attending physicien Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobecco use contribute to the cause of death? 3 Probably 4 ☐ Unknown ate has been signed by page 2 should be detec 1 Yes 2 No þ 24b. Were autopsy findings aveilebla prior to completion of cause of death? 24a. Wes en autopsy performed? Be Completed this certificate hes 2. No 1 Yes 1 ☐ Yas 2 ☐ No Attending Physicien: 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1√2 Inpatient 2 ☐ ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury at Work? After 5 Panding investigation 1 Natural 2 Accident 1 Yes 2 No death. Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Box 68760, P.O. Division of Vital Records. or A after

filled in by To the Hospital within 24 hours a To the Funeral C completely

State Registrar 4 Homicide

29a. Certifier

29b. Signature end title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

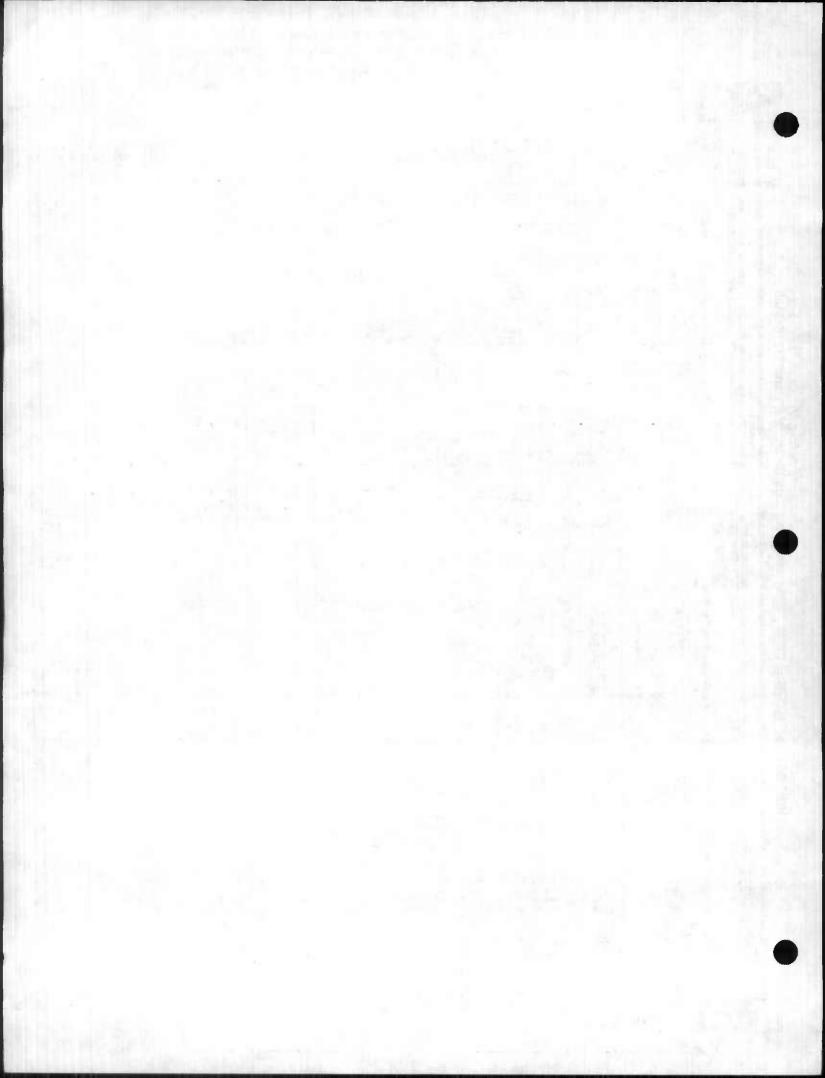
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ackerman rStuart

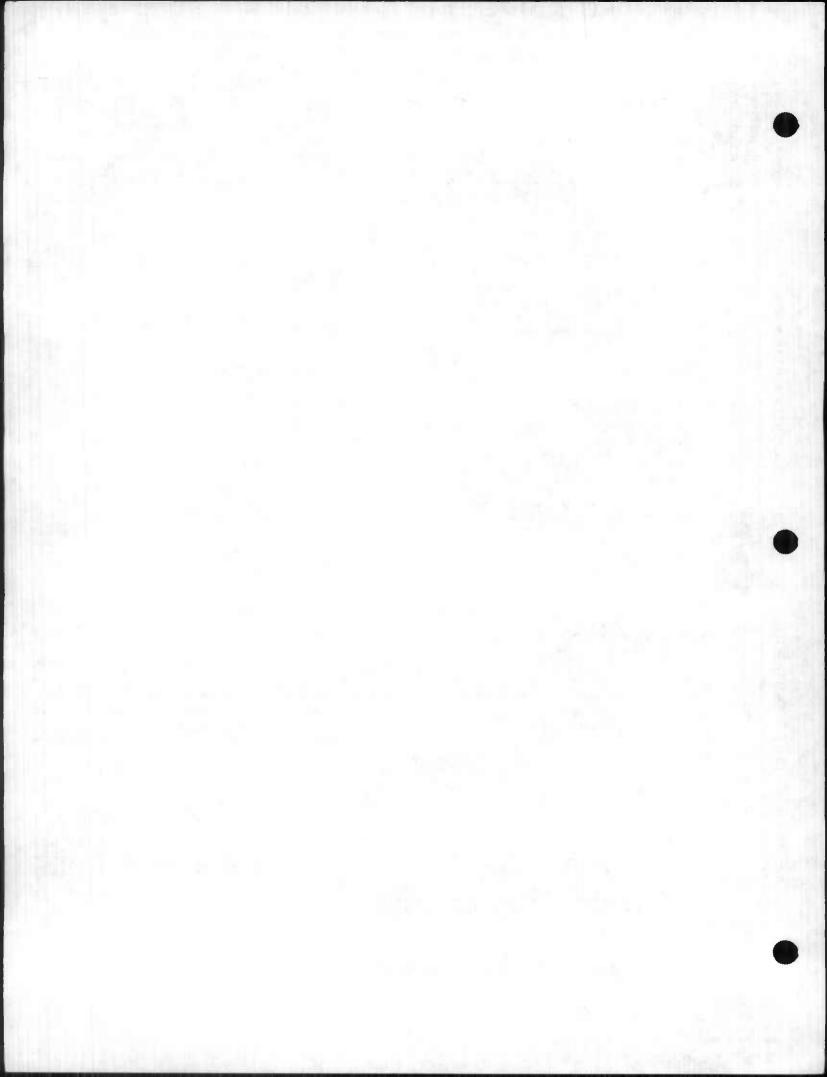
31. Date filed (Month, Day, Year) AUG 21 2000

9000 f manklin 22. Registrar's Signetur

Maryland

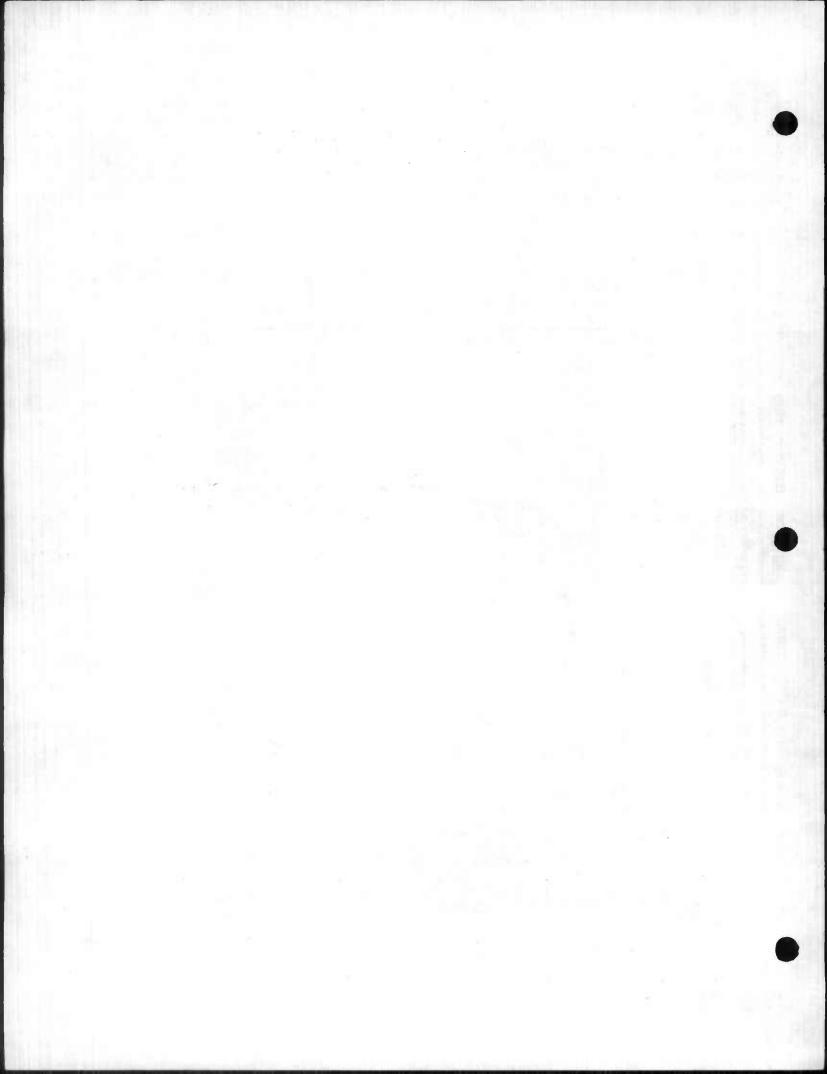


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SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIRESVILLE, MD 21208 **Sequentially list conditions on each wine and one of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of dying, such as cardinac or respiritory strest. **Description of the mode of the mode of the mode of the mode of the mode of the mode of	The state of				temoval from State	ARL	INGTON-	-CHIZUK	AMUNO	8/18/00	BALT	TIMORE	,MD.
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State of Maryland / Department of Health and Mental Hygiene

			C	ertificate d	of Death		Reg. No.	0 26363	
Physician	1. Decedent's Name (First, Middle, Las	Day	Year 3. Time of Death						
/Medical	4a Facility Name (If not institution, give	IIILE	Location of Deat	-3/-0	0 10 aini				
Examiner	A Pacinty Name (in not institution, give		2185	5	1	MORE.	h 4c. County	of Death	
Emeral	5. Social Security Number 6. S	001		1 011 1 111		s. 8. Date of Bir	rth	9. Birthplace (State or Foreign	
Funeral Director		ØM 2□F 69		Months Di	ys Hours Mir	. (Month, Di	ay, Year)	Country) unknown	
8 m	10a. Stata 10b. County	10c. C	ity, Town or	Location				10d. Inside City Limits	
23a or 28a-f show ust be notified at rai Director	MD	F	Baltimo	ore				1 No Yes 2 No	
r tems 23a or 28a-f s incer must be notified Funeral Director	10e. Street and Number			10f. Zip Coo	le		10g. Citizen of W	hat Country?	
al D	2327 N. Charles S	Street	reet 21218				U.S.	Α.	
Instru	11. Marital Status	12. Was Decedent Ever in Armed Forces? UII	U,S. 13	3. Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No		- Amarican Indian, k, White, etc.	
by E.	1 ☐XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1□Yes 2∏		, , , , , , , , , , , , , , , , , , , ,	Specify:		
leted by	15. Decedent's Ed		16a. Dec	pedent's Usual Or	cupation one during most of we	art in a	16b. Kind of Bu	siness/Industry	
np le	(Specify only highest gra	College (1-4or 5+)	life	DO NOT use re	tired)	xxing	rking		
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Be Completed	17. Fathar's Name (First, Middle, Last)					me (First, Middle	, Maiden Sumame	9)	
To	unknown				unknown				
- E	19a. Informant's Name/Relationship (7	Type, Print)			eet and Number or F			State, Zip Code)	
Pert	Noble House	Ion			rles St.,			21218	
Injury or of	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 📉 Other (Specif)	Removal from Stata	cemetery, ci	position (Name or rematory or other	place)	Date	20c. Location - (City or Town, State	
any Injury or	21. Signature of Funeral Service Licen Ronald				dress of Facility natomy Boare, MD 2:		W. Balt	imore Street	
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edical niner	Immediata Cause (Final disease or condition resulting in death)	. HYPOPHAR	YNGE	AL CA	RCINONA			3 months	
6		Due to	(or as a cons	sequence of):					
Examiner		b							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C	or as a corrs	equence of):				at or	
as the	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
for use									
by the attendin	Part II. Other significant conditions of	ontributing to death but not re	23b. Did tobacco usa contributa to the causa of dea						
b b	CVA					10	Yaa 2□ No	3 Probably 4 Unknown	
cate has been signed by the attending page 2 should be detached for use Completed by Physician/N							s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
director, page 2 s		- 111-6				10	Yes 20 No	1 ☐ Yes 2 ☐ No	
director,	25. Was case referred to medical axaminer?	Hospital:				eath (Check only			
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the funer cation	1 Natural 5 Pending Investigation		Injury	M	njury at Work? I Yes 2 No	28d. Describe how injury occurred			
led in by the funeraction:	4 Homicide determined	building, etc. (Spec	City or To	wn, State)	er or Rural Route Number,				
Completely filled in by the funer Medical Certification	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Example 1	raician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, dea ation and/or	ath occurred at th investigation, in n	s time, date and place ny opinion, death occ	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as stated. and due to the cause(s)	
To th	29b. Signatura and title of certifier				ense number		29d. Date signed	(Month, Day, Year)	
5.	aungaradoa				16619		August		
N-1	30. Name and address of person who co	WES 23	m 23a) (Type	e, Print)	6-ST. 1	SAUTING	DRE, MO	. 21218	
State	31. Date filed Morth, Day, Year 1	32 Registrar's Sign	ature	popular	3				



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 8/15/2000 4b. City, Town, or Location of Death 4c. Cc 7:15AM Carl Lewis 4a. Facility Name (If not Institution, giva street and number) 4c. County of Death 4200 Necker Avenue Nottingham Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplaca (Steta or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 1X M 2 F Vrs 65 10/28/34 236-54-7615 Trade, TN Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21236-2922 4200 Necker Avenue 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Bieck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexicen, Puarto Ricen, etc.) 1 XYas 2□ No If Yes, Give Year or Data Vietnam Era 1 Never Married Married 1 ☐ Yes 2 ☐XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 years N/A Bethlehem Steel Team Leader 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumerna) James Christian Lewis Gertrude Elaine Miller 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. informent's Name/Relationship (Type, Print) 4200 Necker Ave. Nottingham, Md 21236-2922 Margot Lewis (wife) 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens 8/19/00 Timonium, MD 22. Name and Addrass of Facility
E.F.Lassahn Funeral Home 21. Signature of Funeral Service Licenses 6. 11750 Belair Rd. Kingsville, MD 21087 23a. Part1. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart fallura. List only one cause on each line. Approximate Interval Batween Onsat and Death immediata Causa (Final 3 Months adensavcinoma disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy periormed? 1 Yas 2 No 1 ☐ Yas 2 No 25. Wes cese referred to medicel examinar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Funeral

Director

ir than "naturel", or Items 23s or 28s-f show

Py

Completed

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or iter any injury or other traumatic event, the Medical Examinat

Baltimore, Maryland 21215-0020

with the Meryland

death

Examiner Physician/Medical p Completed To

physician and the burial-transit 80 attanding 950 for signed by the a peed hes certificate director funeral Certification: or Attending efter death.

Records, P.O. Box 68760,

Division of Vital

Hospital 24 hours 24 hours To the Hosp within 24 hou To the Funer completely fil

State Registrar

SANET CON 31. Date filed (Month, Day, Year) **DHMH 16 Rev 6/95**

Medical

27. Mannar of Death

1 Netural 2 Accident

3 Sulcida

29e. Certifler

4 Homicide

Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretelying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

Discretelying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certiflar 0

5 Pending

invastigetion 6 Could not be determined

soper 30. Name/and address of person who completed cause of death (item 23a) (Type, Print)

1447 DOPER

28a. Date of injury (Month, Day Year)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

1 Yes 2 No

28c. injury at Work?

29c. Licanse numbar

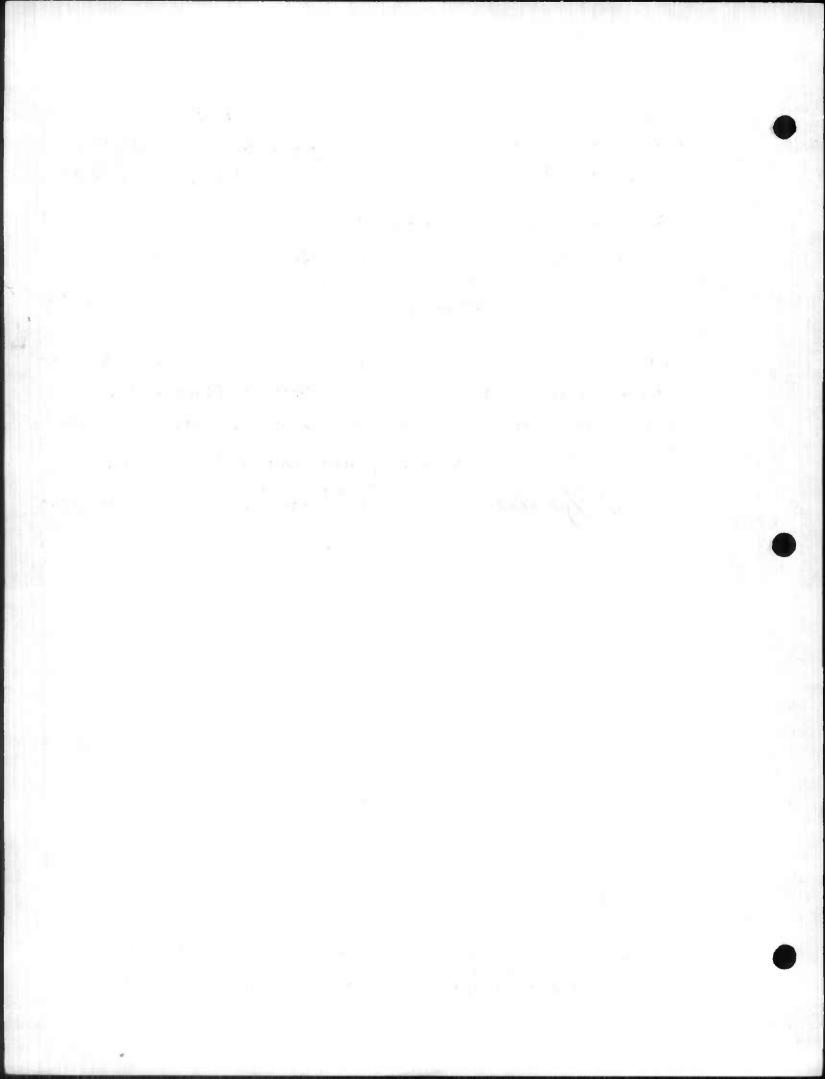
28d. Describe how injury occurred

28f. Location (Streat and Number or Rural Routa Number, City or Town, State)

29d. Data signed (Month, Day, Year)

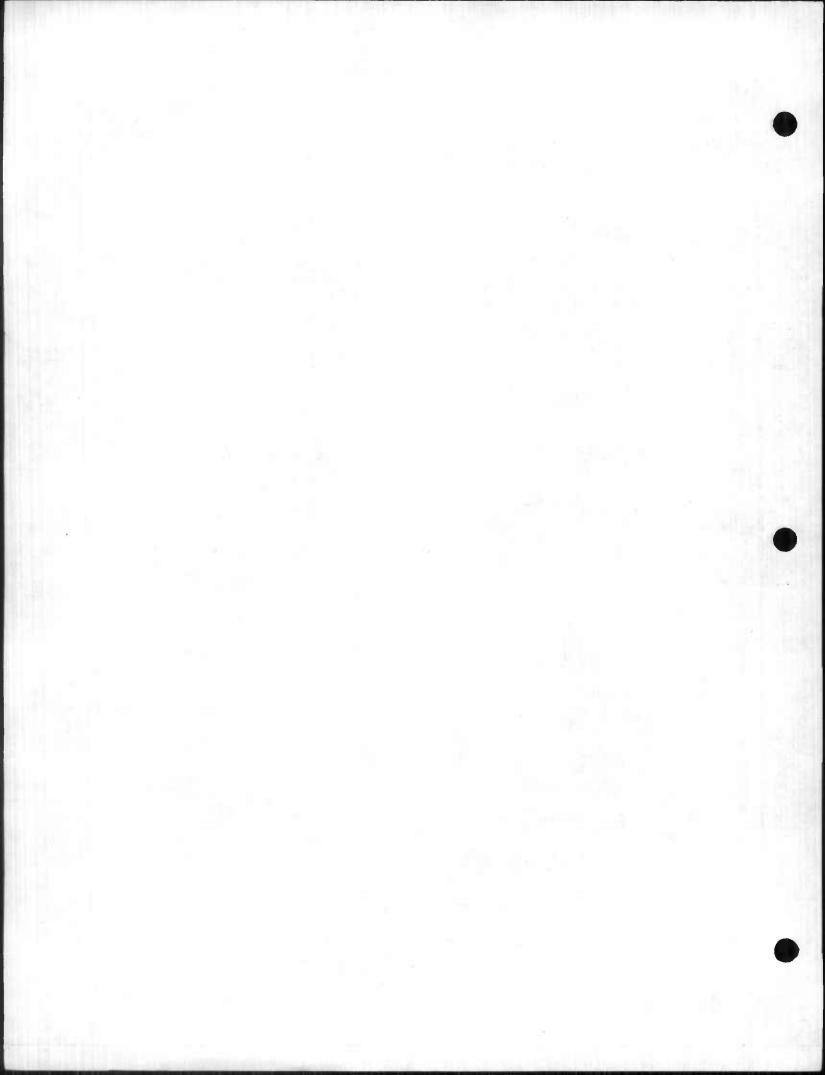
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32. Registrar's Signatule



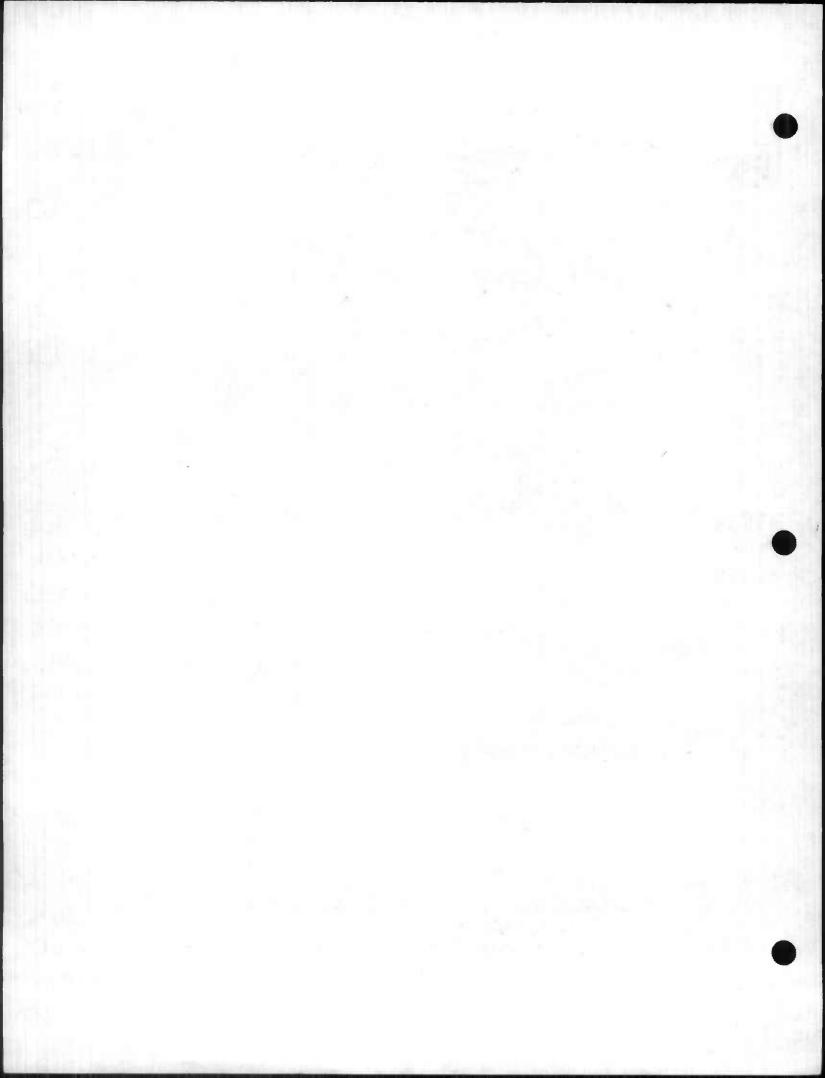
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 05gm Month Year **Physician** DONALD G. LEACH 4e Facility Name (If not institution, give street and number) LEACH AUGUST 2000 18 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** RIVER BAlto MA MIDDLE .Cl. CEALKWAY If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) MD, **Funeral** 12M 20 F Months Days Hours 215-46-7162 Director Usuel Residence of Decedent 10a. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MIDDIE Director 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 8 21720 WALLLWAY 01. 238 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 11. Maritel Sfetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify specity: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiens. Elementery/Secondery (0-12) Cottege (1-4or 5+) 12th MAINTANCE NIA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nant of Health and Mental Dorothy Dolbman -CACH KNIND 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Retetionship (Type, Print) of Health a If Item 27 is or other tree Pine Knob RD. P.A. 16667 Linda LEACL 0 SterBurg 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 8/2/ 1 Burlel 2 Cremetion 3 Removal from Stete Department of Important: If any injury or Cemeter 00 4 ☐ Donetion 5 ☐ Other (Specify) Greenmeunt BAlto. 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licenses Home CHID. Funeral HARTLEY Miller Funeral Home CI 527 HARFORD FD. BALTO-MD Wille 7527 23e. Perfl. Erner the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequenca of) Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760, the Due to (or as a consequence of): r use as 1 P.0. Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yee 2 No 3 Probably 4 Unknown Division of Vital Records, Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2000 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 Other (Specify) this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? After Neturel 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fundamental parts. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Cartifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signaline and sitle of certifie 29c. License number

State Registrar



State of Maryland / Department of Health and Mental Hygiene

4.3	Certificate of Death Reg. No. 00 25366
Physician /Medical	1. Decedent's Name (First, Middle, Last) 2. Date of Death And Pay Average 4. County of Death 4. County of Death 4. County of Death
Examiner Funeral Director	5. Social Security Number 327-24-0065 7. Age (In yrs. lest birthday) H Under 1 Yeer H Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 328 F 73 Yrs. Months Days Hours Min. 03 30 1927 111inois
Phow .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	FL Broward Fort Lauderdale 10g. Citizen of What Country?
al Dir	2441 SW 82nd Avenue #102 33324 USA
alt, or thems 23s or 28s-fs raction must be notified by Funeral Director	11. Merital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Merried 3 No II Yes 2 No II Yes Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 14. Rece - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuben, Mexican, Puerto Rican, etc.) 16. Yes 2 No II Yes 2 No Specify: 17. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuben, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuben, Mexican, Puerto Rican, etc.)
Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher/Administrator Public School
Se Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme)
To	Leslie Welsh Anna Grant
ny or other traus	19a. Informant's Name/Relationship (Type, Print) Thomas Mooney/Son 20a. Method of Disposition 18 Buriel 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 335 Wright St, #203 Lakewood, Colorado 80228 20b. Placa of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery 08/23 Wheat Ridge, Co.
any inju	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, In 736 Edmondson Ave, Balto, Md 21228 23a. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
an al er	Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of):
use as the buriel-transit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Lewlew C. Due to (or as a consequence of): Lewlew C. 1 year 1 year
/ Physicia	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death of the cause of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the cause of death of the caus
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Be Co	25. Was case referred to medical 26. Place of Death (Check only one)
on: To	examiner? 1 Yes 2 No Hospitel: Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Injury at Work? 2 Accident Investigation New Signature 1 Yes 2 No
pletery lilled in by me funera edical Certification:	3 Suicide 4 Homicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
completely filled in by the functional Medical Certification	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.
No No	29b. Signature and William of contribution of contribution of the
Q	30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) 510 Lunuix Ave, Bretimone, MO 21215
State Registrar	31. Date filed (Month, Day, Year) 32. Registrer's Signature AUG 2 1 2000 Several Months (Month) Day, Year)



State of Maryland / Department of Health and Mental Hygiene 00 25357

					Cert	tificate of	Death		Reg. No.		0001	
	1. Decedent's Neme	(First, Middle	e, Last)	18.2			THE VELL	2. Date of D Month	eeth Day	Yeer	3. Time of Death	
Physician /Medical	Jame	es. M	briodis					August	10	2000	1:45 AM	
Examiner			n, give street and num	iber)			4b. City, Town, o	r Location of Dea	- K	- V V		
Examiner	Frankl	2 01	ware Ho	spital	Cente	01	Roses	100	Rol.	timor	0	
Funeral	5. Social Security Nu		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	S. R Dete of B	irth	9. Birthpiec	e (State or Foreig	
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fand	10a. Stete	10b. County		10c. Cir	ty, Town or Loca	ation	- 4			10d.	Inside City Limit	
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	11. Meritel Stetus 1 ☐ Never Merrie	- X	Armed For	C09?	13. 11	Yes, specify Cul	Hispanic Orlgin? (pan, Mexican, Pue	rto Rican, etc.)	Bled	ck, Whita, etc.		
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72 72 net		Decedent ify only highes	t's Education st grede completed)		16e. Decede	ent's Usuel Occur and of work done	pation during most of w ed)	orking	16b. Kind of B	usiness/Indus	try	
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Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mental hygiene. 7 is marked other than "natural", or theumatic event, the Moderal Event To Be Completed by F	19a. Informent's Ner						t end Number or I				ode)	
Hasith Hasith om 27 other tr	Isabel Mo	oniodis	s- Spouse				Road Balt	cimore,	Maryland	21236		
Baitimore, Maryiand 212 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any Injury or other treumatic event, the pages. To Be Comp	20a. Method of Dispo			20b. F	Plece of Disposi	ition (Neme of etory or other ple	ece)	Dete	20c. Location -	City or Town	, Stete	
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Baiti permit. Departu importa any inju	21. Signeture of Funerel Service Licensee Heather Cain 22. Name end Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryla										21214	
	OCO Post Estable	المع	en la									
	shock, or heert	t feilure. List	complications that ca only one cause on ea	ich line.	n. Do not enter	r the mode of dy	ing, such es cardi	ec or respiratory	911951,	In	oproximate tervel Between nset and Death	
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/Medical Examiner	Immediate Cause (F disease or condition resulting in deeth)	T WI BI	·Inte	x5+1+1	ial P	simon	ary Fi	brosis			s days	
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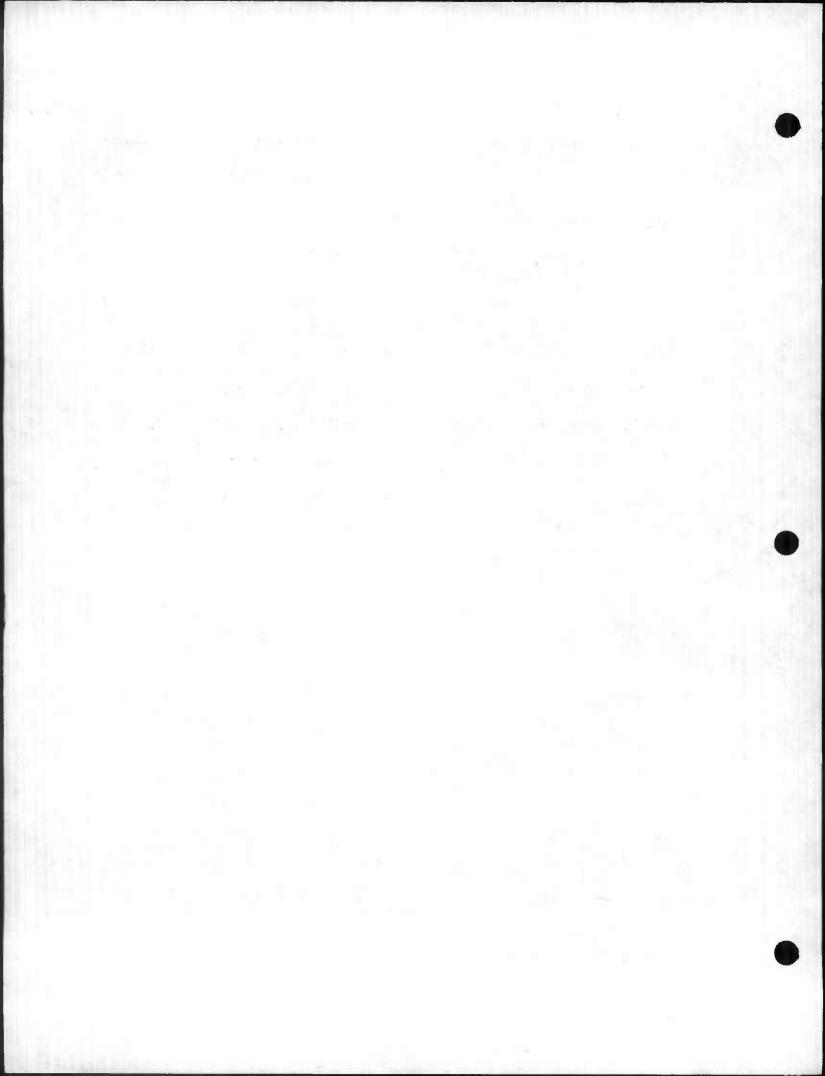
State of Maryland / Department of Health and Mental Hygiene

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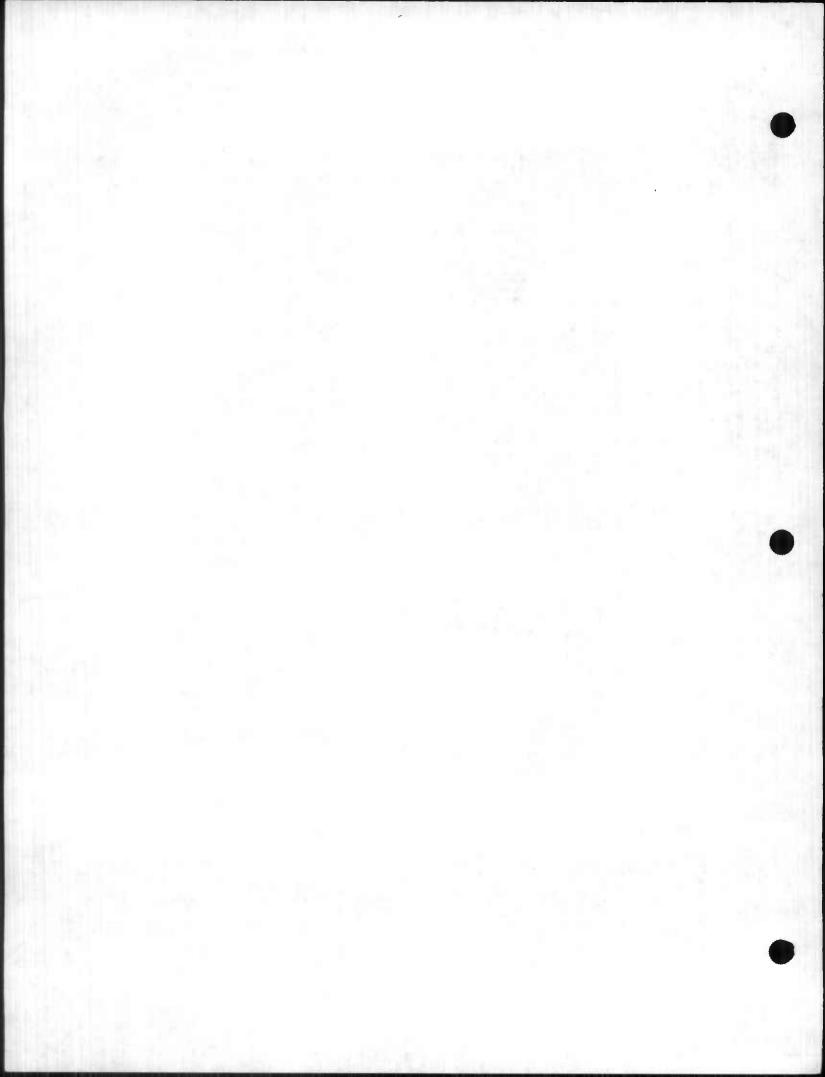


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** NOVASH L015 08 7:25 AM 2000 /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 24 Hrs. 8. Date of HARBOR HOSPITAL CENTER If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1□ M 20XF Yrs. **Director** 343-01-3058 26, 1917 Maryland Usuel Residence of Decedent the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumeds event, the landical Examinar must be notified at 1 X Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Light Street, Apt. 818 21230 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 14. Rece - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Etementary/Secondery (0-12) Cotlege (1-4or 5+) unknown unknown 12 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental th Important: if fem Z7 la marked oth any Injury or other traumatic even Boca. Be Samuel E. Plecker Eva Coleman 19a. tnformant's Neme/Reletionship (Type, Print) 19b. Mailing Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Heiberman/daughter 11442 Glen Arm Road, Glen Arm, MD 21057 20b. Plece of Disposition (Neme of cametery, crematory or other placa) 20e. Method of Disposition Date 20c. Location - City or Town, Steta 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility IIAM, 814 Cedar Avenue, Scranton, PA Ronald S. Wade, Diretor 18505 1 caro nauni Aurtl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, or heert feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical METASTATIC SMALL CELL CARCINOMA OF LUNG Examiner Due to (or es e consequence of): Examiner NEUMONIA the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last and Due to (or as e consequenca of): certificate be exec attending physician. CONGESTIVE Box 68760 Physician/Medical Due to (or es e consequence of) 88 SEPSIS 980 23h. Did tobacco use contribute to the cause of death? P.O. the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 Pros 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2 No certificate Be 25. Wea case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 21 No 10 1 Impatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28c. Injury et Work? Certification: Attanding 5 Pending investigation 1 Waturel death. 1 Yes 2 No 2 Accident To the Hospital or Attance within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, atreet, factory, offica building, etc. (Specify) illed in by 4 Homicide 1 Descripting Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 3904 2000 Neme end address of person who completed cause of death (Item 23a) (Type, Print) Harmy HOS Pilou curture MAGADDA

State Registrar

32 Begluttar's Sign



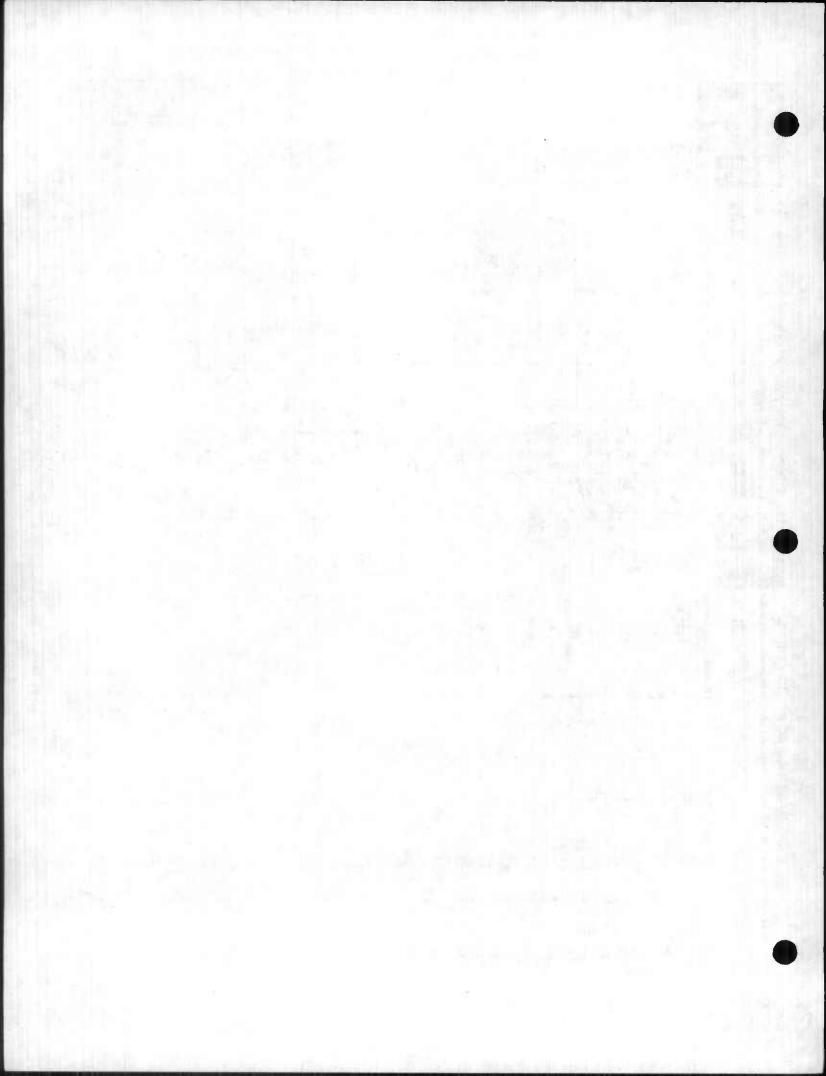
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 17,2000 4c. County of Death 4b. City, Town, or Location of Deeth /Medical 4a Facility Name (If not Institution, give street end number) Examiner IRRY 1401104 6. Sex **Funeral** 10 M 20 F Director Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Ves 2 No **Funeral Director** 109 Street and Number 10g. Citizen of What Country? 10f. Zip Code death Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Nerra 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 B No If Yes, Give Year or Dates: 1 Never Married 2 Married ack Baltimore, Maryland 21215-0020 1 Yes 2 No Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. ondary (0-12) College (1-4or 5+) reman other Father's Name (First, Middle, Last) h end Mental P Pages 1 and 2 should be Rural Route Number, City or Town, State, Zip Code) ationship (Type, Print 20c. Location - City or Town, State DUITO Depertment of Health Important: If Item 27 20b. Placa of Disposition (Name of Date 5 1 B Burial 2 ☐ Coethation 4 □ Donation 5 Other (Specify)

21. Signature of Poteral Service Ligens Pu or complications that caused the death. Do not enter the List only one ceuse on each line. Approximate fntervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DIRatore Examiner Due to (or as a consequence-of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) use as the burial-tre P.O. Box 68760, Due to (or as a consequence of) funerel director, page 2 should be detached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To ER/Outpatient 3□ DOA 6 ☐ Other (Specify) 5 Residenca 27. Manner of Death 28b. Time of 28c 28d. Describe how Injury occurred Injury at Work? After 1 Natural 2 Accident 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) completely filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License numbe 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Molnic South BR 11. Date filed (Mont 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



hysician	 Decedent's Neme (First, Middle 	, Last)			tificate of		2. Date of De	eath	1	3. Tima of Death			
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xaminer	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or I							th 4c. County	of Death				
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To B	Francis Wil	liam Pyle				Ruth D	Dorothy Brooks						
-	19a. Informant's Name/Ralationsh	ip (Type, Print)		19b. Mailing	Address (Street	et and Number or R	ural Routa Numi	ber, City or Town,	Stata, Zip Co	ode)			
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any injury	21. Signature of Funaral Sarvice L		Name and Add										
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1 XYas 2 No 27. Mennar of Death 1 XNatural

5 Panding invastigation 2 Accident 6 Could not be datamined 3 Sulcida 4 Homicida

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28b. Tima of Injury 28a. Deta of Injury (Month, Day Year)

28c. Injury at Work? 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how injury occurred

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

1 Certifying Physician: To the best of πy knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of cartifiar

29c. License number O.C.M.E. 29d. Data signed (Month, Day, Year) August 14, 2000

30. Nama and addrass of person who complaied causa of death (Itam 23e) (Type, Print)

ARY G. HIPPE, M.P. 111 Beni Benn Street, Baltimore, Maryland 21201

State Registrar

AUG 2 1 2000

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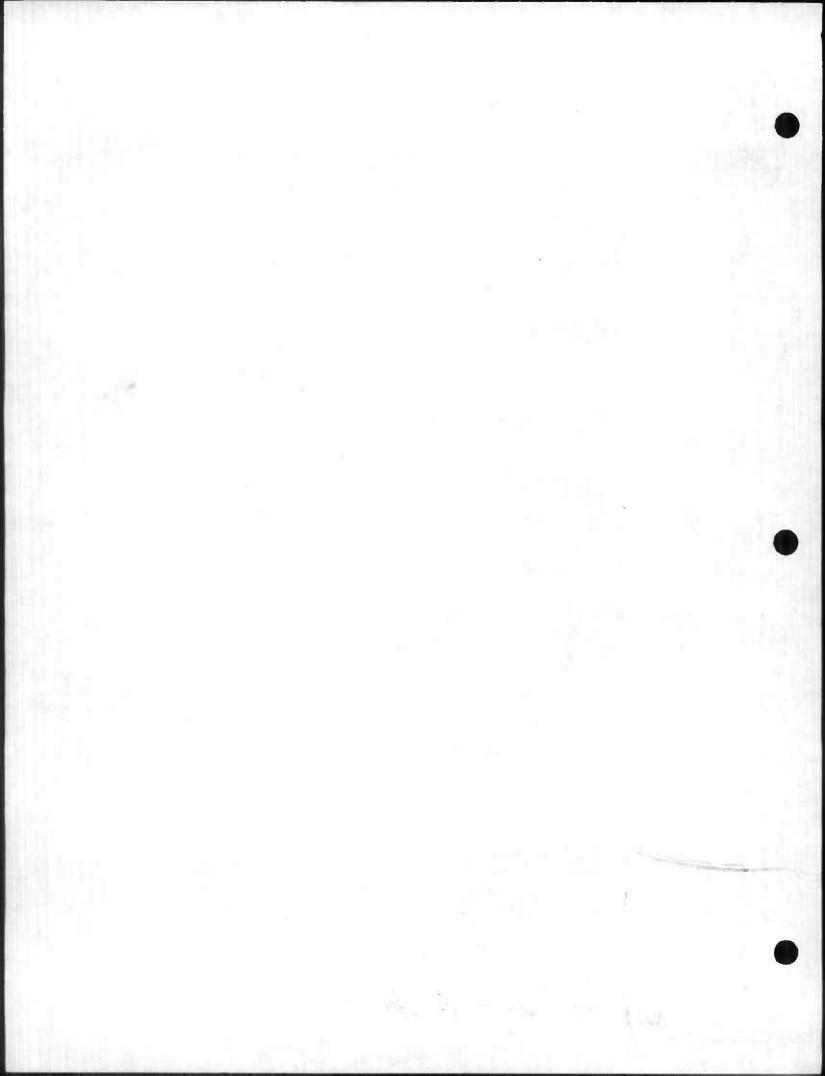
To the Hospital or Attanding Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 s

Medical Certification: To

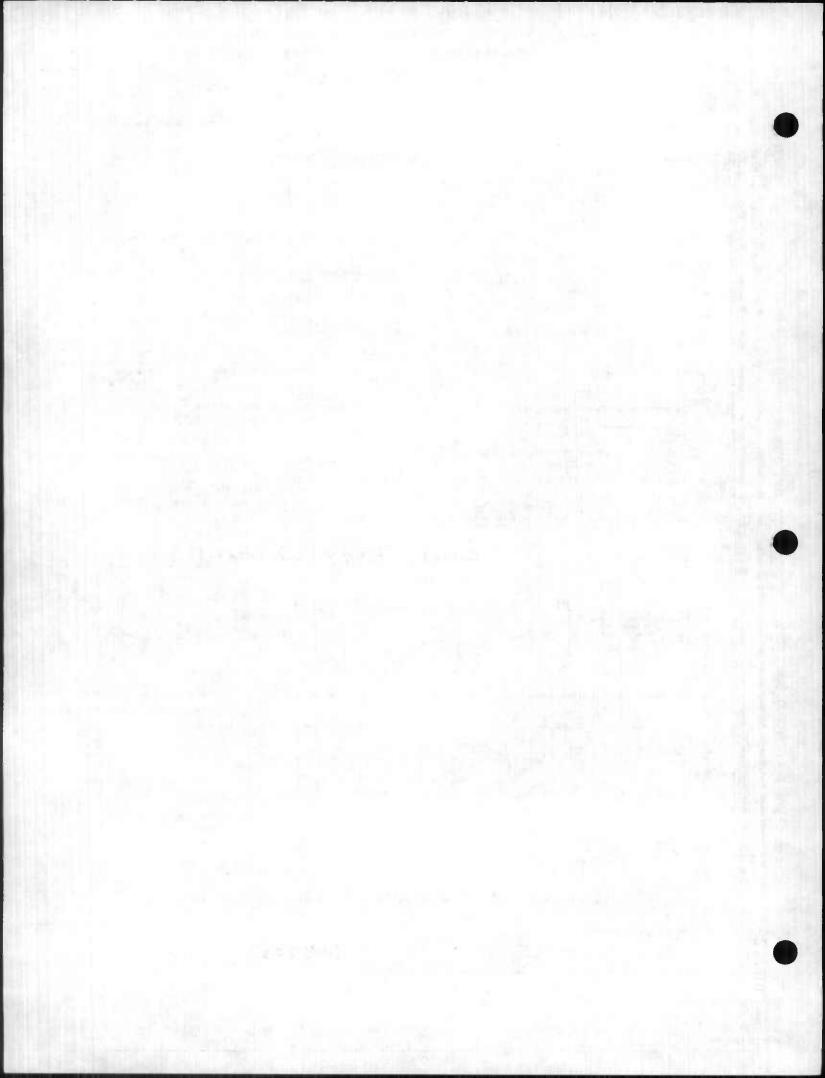
29a. Cartifiar

Division of Vital Rec



State of Maryland / Department of Health and Mental Hygiene 00 26372

Allerided J	telisir 10017a pet Fil Gr	01 9-5-00 M33	,	Certificat	te of	Death			Reg. No.		-0012
	1. Decedent's Neme (First, Middle, L.	est)			-			2. Date of Dea Month		Year	3. Time ot Deeth
Physician	Isabel E.		August		Day 200		11:41 AM				
/Medical Examiner	4a Fscility Name (If not institution, gi	ve street and number)			- 1	4b. City, To	wn, or Loc	ation of Deeth			
Examination	Stella Maris					Timoni			Balt	imore	
Funeral Director		Sex 7. Age	e (In y.rs. last birth	Months	Days		Min.	8. Date of Birth (Month, Day Feb. 6	y, Year)	Coui	place (Stata or Foreig ntry) yland
	Usual Residence of Decedent										
4	10a. Stete 10b. County		10c. City, Town	or Location							10d. Inside City Limits
Į o	Md. Baltimor	e	Timoniu	ım							1 ☐ Yes 22 No
Director	10e. Street and Number				o Code				10g. Citizen of 1	What Cou	ntry?
	2300 Dulaney Va	alley Rd.		2	1093					USA	
Funeral	11. Marital Stetus	12. Wes Decedent E Armed Forces?	Ever in U,S.	13. Was Dece It Yes, spe	dent of I	Hispanic Original	gin? (Spec	cify Yes or No-	- 14. Rac	e - Americk, White,	can Indian,
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo	1 ☐ Yes				noan, oto.,	Specify		
Completed	15. Decedent's E (Specify only highest gi		16a. I	Decedent's Usu 'Give kind of wo	al Occup	pation during most	t of workin	ia l	16b. Kind ot B	usiness/In	dustry
mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT u	ise retire	∌ d)			T1	- 1	
	12	A1	Ac	ccounti	ng S		****	/Circo Adiddle	Hospit.		
Be	17. Fether's Name (First, Middle, Las	0				18. Mother's Name (First Middle, WEIZELBERGER) Mary Wetzelbur			Maloen Suman	10)	
2	Michael Peters						-				
	19a. Informant's Name/Raletionship NAVARRE Mary Navalle/ Nie	(Type, Print)							or, City or Town, Md. 210		p Code)
	20a. Method of Disposition	- 1000000000000000000000000000000000000	20b. Pleca of I	Disposition (Na	me of	ica)		Dete	20c. Location	City or T	own, Stata
	1 ☑ Burial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Special			er Cem	. 18-	-23-00	Baltim	ore,	Md.		
	21. Signeture of Funeral Service Lim		11.00	22. Name at	nd Addr	ess of Facilit	ty				
	1 4 1								Home, I		
	23a. Part1. Enter the dise shock, or heart failure. List his	noticeties that sourced	To dooth Do no	at enter the mor	1050	York	Rd.	Towson	, Md. 2	1204	Approximate
edical Examiner	Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or injury that initiated events	Due to (or as a co	ue to (or as a consequenca of): ue to (or es a consequence of):								
Medical	Cause (Disease or injury that inflated events resulting In death) Last	Due to (or es a co									
Physician	Contil Cabourdon Management			M - 4 4 4 .		San to Decid	12.11	ook Bid		m And broken d	a sha same ad da at
iysi	Part II. Other significant conditions	contributing to death bu	at not resulting in	tha undarlying	cause g	iven in Part I					to the cause of death
by Pt								10	Yes 2 No	3 Pro	bably My Unknow
tolen: The taw requires that the certificate has been signed by the rector, page 2 should be detached by Be Completed by Phys.									an autopsy ormed?	a	Vere autopsy tindings vailable prior to ompletion of cause f daath?
								10	Yes 2∑No		☐ Yes 2☐ No
BeC	25. Was casa raterrad to medical					26. Place	e of Death	(Check only o	one)	1	
To Be	examiner?	Hospital: 1 Inpatie	nt 2 ER/Out	patient 3 D	OA OI	th mar			dence 6 □Ott	ner (Speci	ify)
To the Hospital or Attending Physicien: within 24 hours after death To the Funeral Director: After this certific completaly filled in by the funeral director. Medical Certification: To Be it	27, Manner of Death	28a. Date of Injury 28b. Time of Injury Work?							how injury occu		
	12 Natural 5 Panding 2 Accident investigation					Yes 2	No				
	3 Suicide 6 Could not determined		ury - At homa, fam c. (Specify)	m, street, tactor	ry, offica		2	28t. Location (Street and Number or Rural Route Number City or Town, State)			
edical Co											
Med		one) and manner stated.							20d Date signs	d /Month	Day Vees
-	29b. Signature and title of codition	~ ~		29			29d. Date signed (Month, D				
	1 /2	-		31013	D	437	25		A46.	18, 2	2000
7	30. Nama and address of person who	completed cause of de	eath (Item 23a) (1	Type, Print)			N.				
'	Tariq Mahm	nood, M.D.	2300 Du	laney V	alle	ey Rd	T.	imonium	n, Md 23	1093	
State	31. Date filed (Month, Day, Year)	1	er's Signature								
naictrar	AUC 9 1 2000	6.	6 1	1							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26373 Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 0040 17 2000 Agnes Rebstock 4b. City, Town, or Location of Dualin 4c. County of Deat 4a Facility Name (If not institution, give street and number) Maryland Baltmore gnes x 1 m If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. lest birthdey) Days 1 M 2 F 114-01-2847 Yrs. Germany Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Nos 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 721 Nottingham Road 21229 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Rece - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stefus 1 Never Merried 2 Merried 1 Yes 2 No Specify: 3 ■ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Factory 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard F. Jupitz Margarete L. Ebering 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Elsie Jupitz/Sister 721 Nottingham Rd, Baltimore, Md. 21229 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ■ Burial 2 □ Cremetion 3 □ Removel from State 08 19 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 22. Nome and Address of Facility 21. Signeture of Funeral Service Licensee Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228 St. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last dio genic Due to (or as a consequence of). 29449 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 14 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No emon 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dopatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Ccident 5 Pending investigation

Vital

Examine Physician/Medical Be Completed by

Medical Certification: To the Hospital within 24 hours

Physician

/Medical

Examiner

Funeral

Director

-

r than "natural", or items 23a or 28a-f ehov The Medical Expensiver mast be notified at

al Hygiene.

1 and 2 should be fill Health and Mental H m 27 is marked off

permit. Pages 1 and 2. Department of Health at Important: If Item 27 is any injury or other tree

Physician

/Medical Examiner

72 hours after

Baltimore, Maryland 21215-0020

Directo

Funeral

à

Completed

Be

State Registrar DHMH 16 Rev 6/95

To the

29b. Signature and little of certifier wa

3 Suicide

29a, Certifier

4 Homicide

6 Could not be

Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

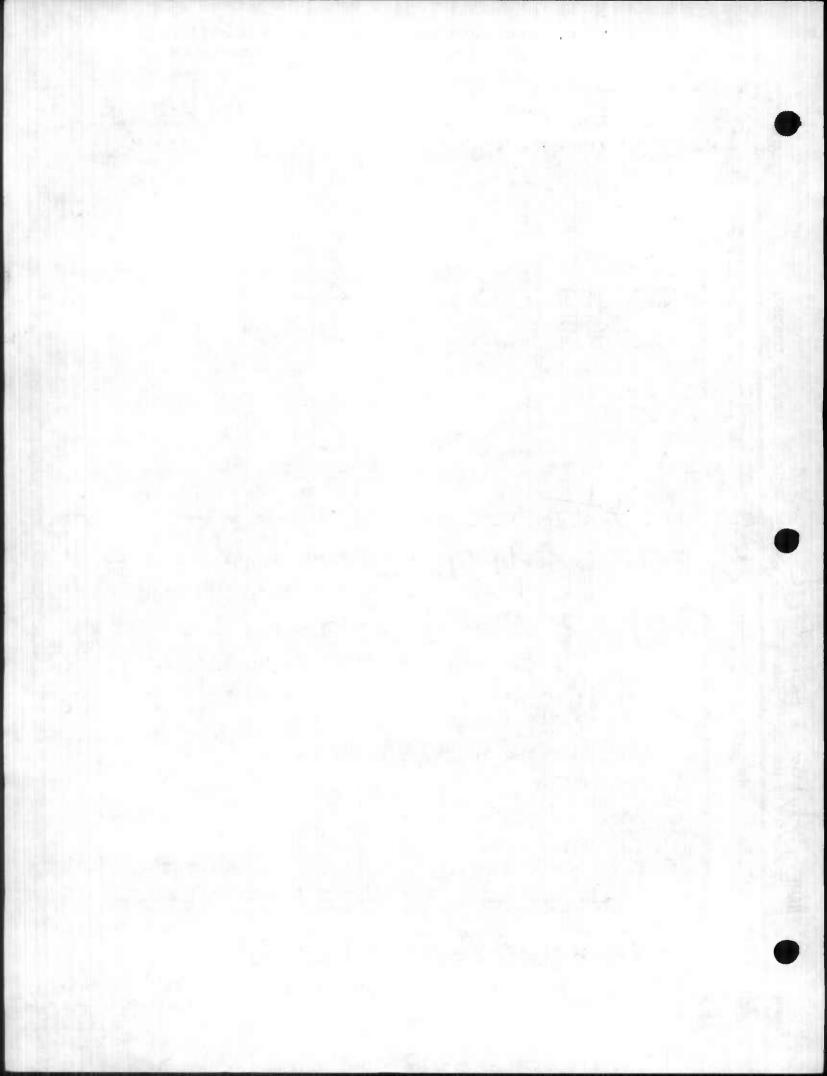
1. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29d. Dete signed (Month, Dey, Year)

Soul

31. Date filed (Month, Dey, Year)

AUG 21

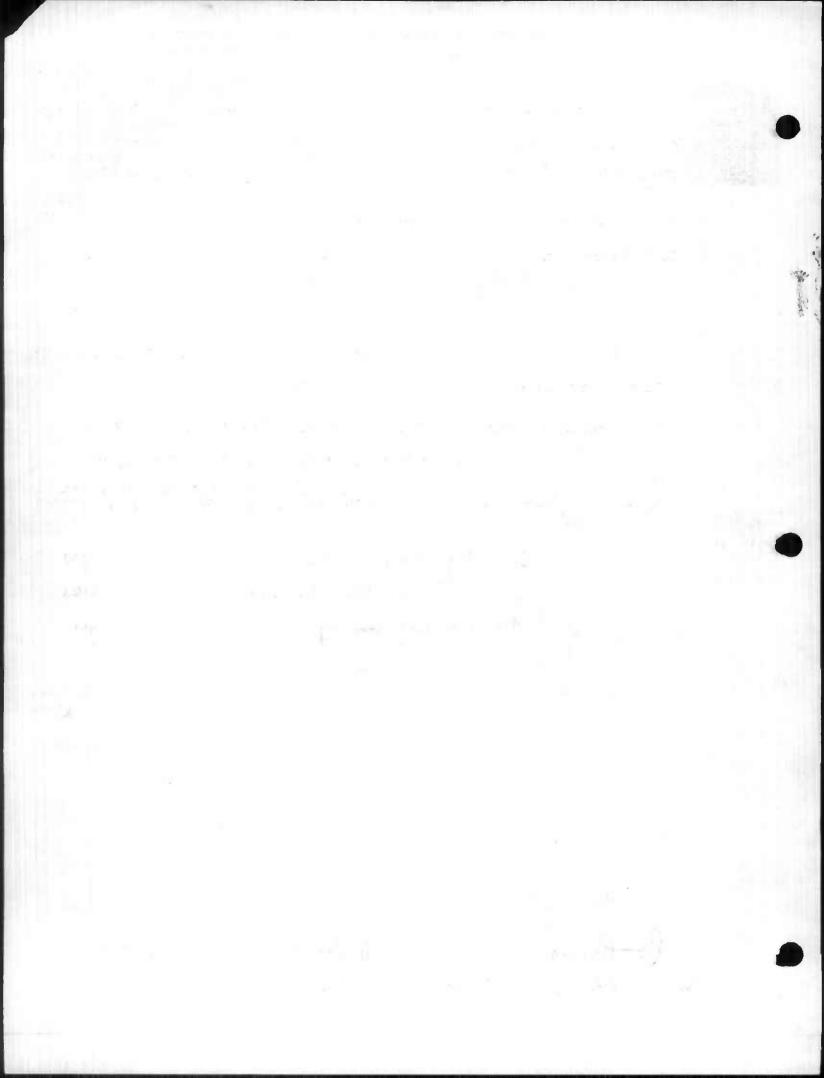
32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

26374 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 5:45 pm Herman S. 2000 August 20 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Lorien Nursing Home Columbia Howard If Under 1 Year if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year)
July 25,1917 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days 1 □XM 2 □ F 220-03-9094 83 Yrs Director Maryland Usual Residence of Decedent e filed within 72 hours efter death with the Maryland al Hygiene.
other than "natural", or items 23a or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits troumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2929 Rosemar Dr. Ellicott City United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Engineer C & P Telephone Co. 17. Fether's Name (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental Hy lant: If Item 27 Is marked oth 18. Mother's Name (First, Middle, Melden Sumeme) Be Herman Henry Roemer Eve Seek 20 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) other 1 Katherine Roemer / spouse 2929 Rosemar Dr. Ellicott City, MD. Baltlmore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burlel 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If any injury or once. injury or 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 8-23-2000 Elkridge, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. Spolosy 4112 Old Columbia Pike Ellicott City, MD 21043 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due (of es a consequence of): Examiner Aspinsta The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last burial-tran Due to (or as a consequence of): Box 68760. attending physician Askus -Stones no Long Physician/Medical the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Binknown Division of Vital Records. PV 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? has 1 Tyes 2 No 1 ☐ Yes 2 ☐ No certific or Attending Physician: Be 25. Was case referred to medicel examiner? 26. Piece of Death (Check only one) Other: 4X Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel daath. 1 Yes 2 No 2 Accident after daath Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(e) 29e. Certifier Medical and manner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) to Fuelle August 21, 2000 and address of person who completed cause of death (Item 23a) (Type, Print) banks dewher 11055 Patrus Signature - ATTO State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Year Robinson **Physician** Tireice 9:13 Pm August 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner of Meryland Medical System

8. Sex 7. Age (In yrs. last billinday) Hu Baltimore Baltimore University If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number Birthplace (Stata or Foraign Country) Months Days Hours 1□XM 2□ F 6 Yrs. Unknown Director 10-17-93 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Directo MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2623 Park Heights Terrance 21215 USA Funeral Hems! 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried 6 Maryland 21215-0020 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) NA then Elementary/Secondary (0-12) Ist. Grade Child Child 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be nent of Health and Mental Lawrence Jackson Cindy Hitchcock 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 21217 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar Important: If Itam 27 is any Injury or other traughts. .00 Patricia 1214 McCulloh Street Baltimore, Maryland Jackson Baltimore. 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition King Mem. Pk. Cem. 08-10-2000 N Burial 2 ☐ Cremation 3 ☐ Removel from State Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21202 emas WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical moroxide polsoning Examiner Due to (or as a consequence of) inheletion moke Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be execu Box 68760 CERTIFICATION APPROVED BY MEDICAL EXAMINER **Physician/Medical** Due to (or es e consequence of) as the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by ardispulmanary arrest Division of Vital Records. by 24b. Were autopsy findings aveitable prior to completion of cause of death? 24a. Was an autopsy parformed? Completed this certificate has 1 Yes 2 No 1 Yes al or Attending Physicien: The safer death.

In Director: After this certificated in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Chack only ona) Hospital: 1 Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 5:30 AM 1 Yes 205No 2 Accident 17100 House tire 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) yd ul bellif 4 Homicide Home

2623Park Health, Bullmore, Mb

12623Park Health, Bullmor To the Hospital within 24 hours a To the Funeral D completely filled Medical 29a. Certifler 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifie dress of parson who completed cause of death (Item 23a) (Type, Print) Green St Baltimore, MD Stramanis M 225 ohn P. Omms 32. Registrar's Signature State 2000

DHMH 16 Rev 6/95

Registrar

AND IT WAS I THOUSE March Steel periors : Company of the Law St. to Bridge of the Company of the

State

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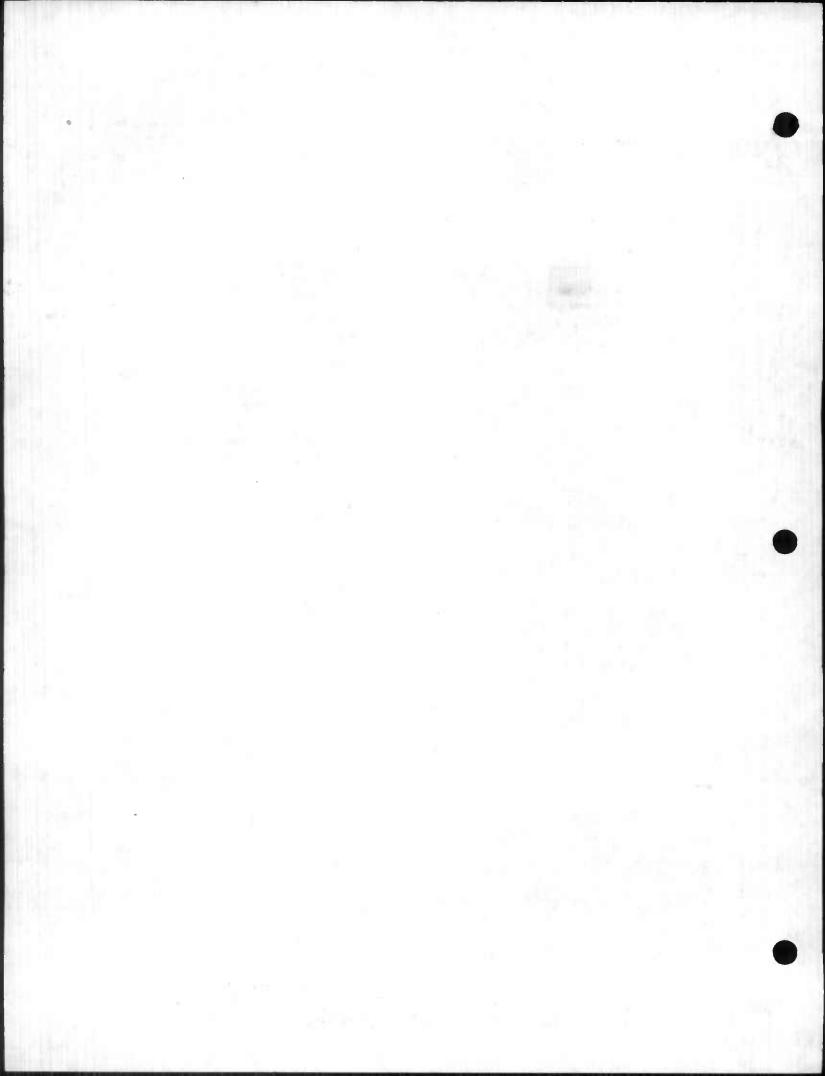
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rudentz

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

AUGUST 19, 2000



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Daie of Death 3. Time of Death Month Year RAY CINTHIA 0250 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL FALLSTON HAZFOLD 4 EN FALLSTON If Under 1 Year | Months | Days | H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 Y 217-64-0707 6/11/56 Balto., MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Harford Baldwin 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13829 Manor Glen Rd. 21013 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 2 2 1 Vo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years years Teacher Balto, County Board of Ed 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Henry Edward Ruppertsberger Marguerite Catherine Albers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jonathan Ray (husband) 13829 Manor Glen Rd. Baldwin, MD 21013 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State St. John's Lutheran Ch Cemetery 8/18/00 Sweet Air. 4 Donation 5 Other (Specify) 21. Signatura of Funeral Service Licensea 22. Name and Address of Facility E.F. Lassahn Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final METASTATIC CANCER disease or condition resulting in death) CANCER Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 25. Was case rafarred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 DYes 2□ No 27. Mannar of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28e. Placa of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

Records, P.O. Box 68760. of Vital or Attending Physician: Division To the Hospital within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Director

Funeral

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Completed

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altimore, Maryland 21215-0020

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Physician /Medical

Examiner

Examiner

Physician/Medicai

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Be Completed

Medical Certification: To

29a. Certifier (Check only one)

29b. Signature and title of certilier

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certificate

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After

after death.

funeral director,

illed in by

DHMH 16 Rev 6/95

State Registrar

31. Date filad (Month, Day, Year) AUG 21 2000

mish

PRABHO

MO 728 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3KLAN MO 21014 BELAZIO

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

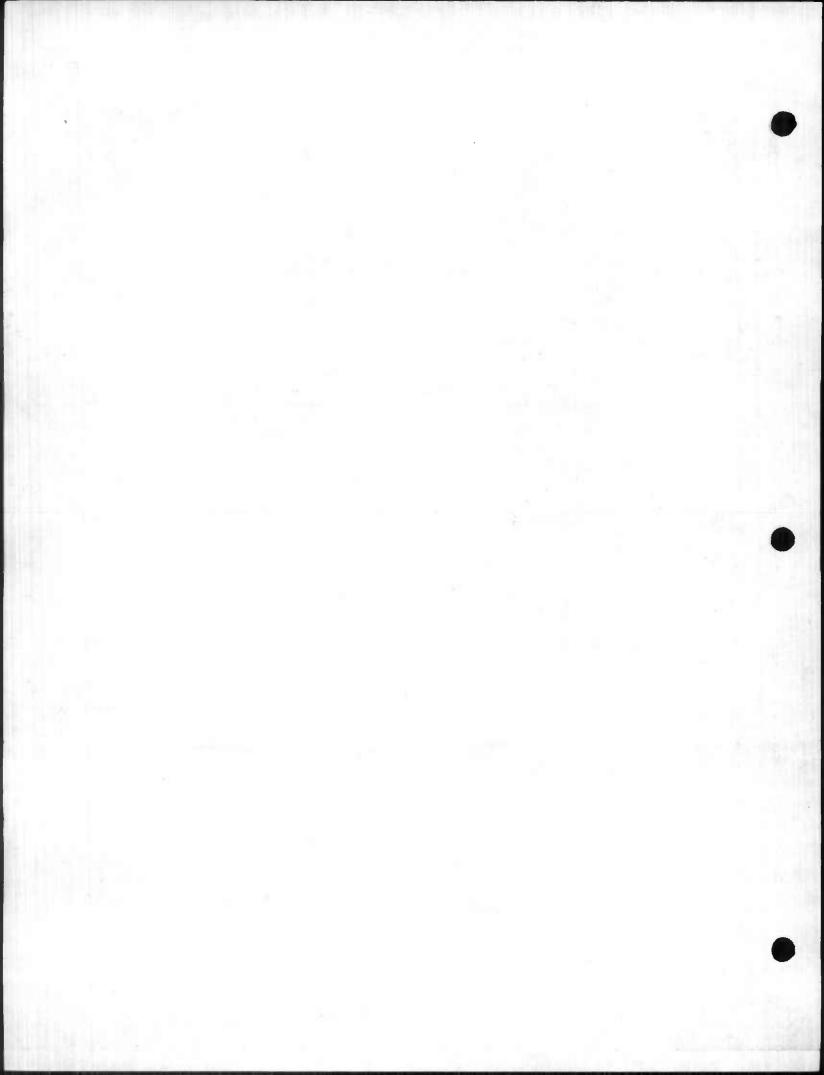
29c. License number

29d. Date signed (Month, Day, Year)

15,

2006

DME



00-4564-027 ADE W. RUFFIN

DHMH 16 Rev 6/95

AMR . . . AAA!

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

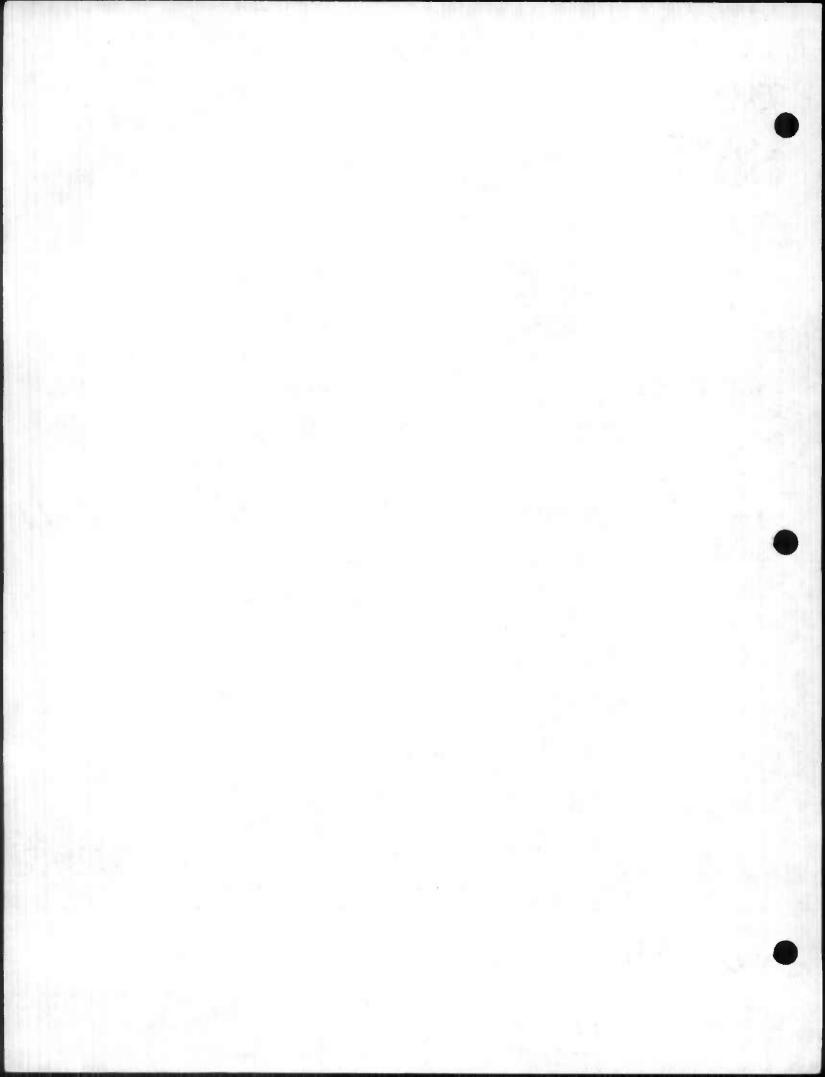
26378

AMEND ITEM: #18 PER F.H. G786 8-19- Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** AUGUST 15,2000 ADEWOLE RUFFIN 02:25 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner LITTLE PATUXENT PKWY @ GOVERNOR WARFIELD HOWARD COLUMBIA 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 12 M 20 F Months Days Hours 142 · 88 - 1390 Usual Residence of Decedent DA -16-Director 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No MO HOWARD COLUMBIA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 5696 THICKET 238 LANE 21044 Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Stetus Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 "natural", or 1□ Yes 212 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) SCHOOL GRADE STUDENT NIA 12-11 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Peges 1 end 2 should be nent of Health end Mentel ALTON RUFFIN BOBI DUNLAP BOBI DUNLAP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 Department of Health e Important: If Item 27 le any Injury or other trai BOBI RUFFIN MOTHER 5696 THICKET LN. 21044 COLUMBIA , MD. 20b. Place of Disposition (Name of cametary, cremetory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 8.19.00 ELKRIDGE, MEADOWRIDGE CEME. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility YAUGHN C. GREENE FUNERAL SERVICE 5151 BAUTO. NIATL' DIKE, BAUTO MO. BAUD. MD. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical Examiner as a consequence of) Examine The law requires that the death certificate be executed ettending physician and for use as the bunal-trensit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760, Physician/Medical that initiated events rasulting in death) Last Due to (or as a consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown Records, py 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2□ No 2 No Division of Vital tal or Attending Physician: The safer death.

In Director: After this certificate ed in by the funeral director, pa Be 25. Was case raferred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Sothar (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural but dur 1 Yes 2 No vilved in acadla 115/00 0215 AM 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Numb City or Town, Stete) Lettle Patrick Conf 4 Homicide governme Watseld Howard L To the Funeral C weeding To the Hospital 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Manual Man edical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. AUGUST 15, 2000 ny 30. Name and address of person who completed cause death (Item 23a) (Type, Print) (HEDDORE MIKE 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year, 32. Registrer's Signeture State AUG 1 9 2000 Registra

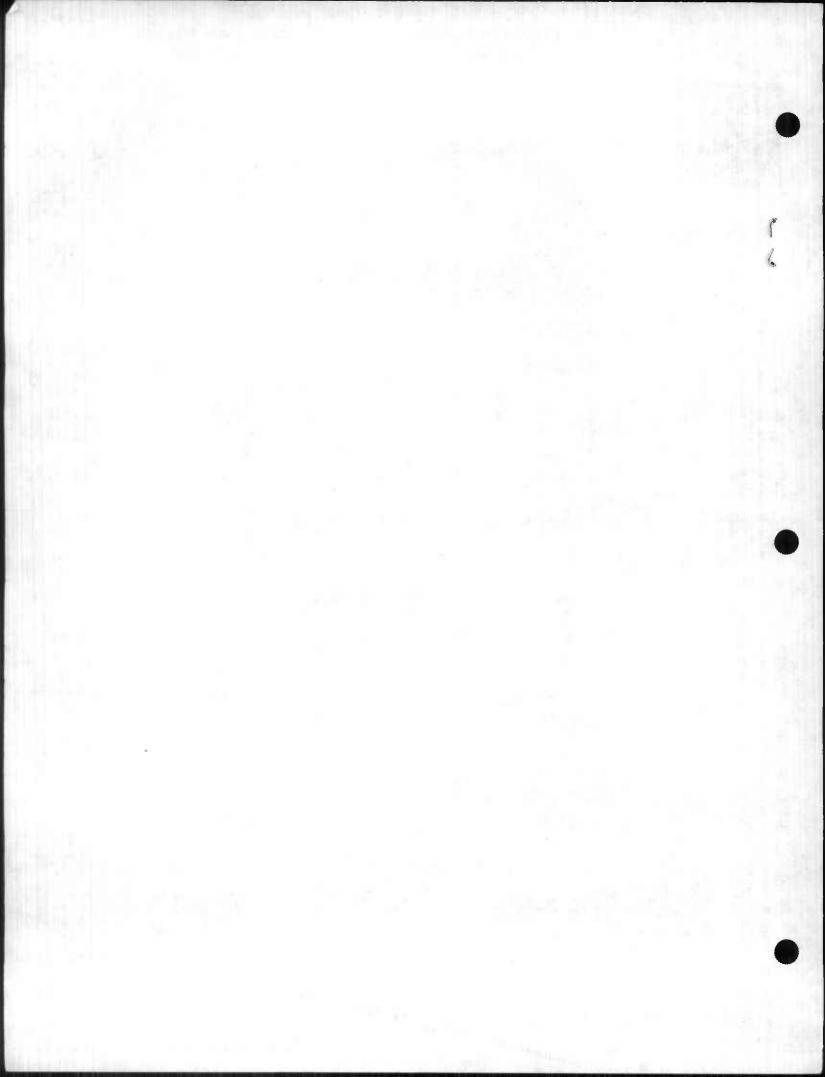
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

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			Certifica	te of Death	R	eg. No.	C	0015		
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Physician /Medical	1 2010012		REAV		AUG-ns		000 10	0:18A		
Examine	BON SECULT A	les pi bel		BAlt		4c. County of	14			
Funeral Director	231016212	M 2□ F 7. Age (In yrs. 53	Yrs. If Und Month	ler 1 Year If Under 24 H s Days Hours M	Irs. 8. Date of Birth Month, Day Mare 10	39947 5	Country)	State or Foreign		
4 show led at	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location BAHHUA					eside City Limits		
at be notified	10e. Street and Number	ton Street.	D 101.2	Pip Code	1		Citizen of What Country?			
Examiner ma	Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 25 No If Yes, Give Year or Detes:	If Yes, sp	pedent of Hispenic Origin? pecify Cuban, Mexican, Pu	penic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. Specify: Specify: B6-CK					
tental Hygiene, teed other than "natural ic event, the Medical o Be Completed	15. Decedent's Edu (Specify only highest grade Elementery/Secondery (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of the life. DO NOT	suel Occupation work done during most of a use retired)	working	16b. Kind of Business/Industry Mary land School				
	17. Father's Name (First, Middle, Last)			/ /	Name (First, Middle, I	Middle, Maiden Sumeme)				
atth and M 27 is mar er fraumat	19a. Informant's Name/Relationship (Ty,	oe, Print 50M	19b. Mailing Addre 34/7 D	uss (Street and Number or Spant Avg		City or Town, SI				
ant: If flam ary or othe	20a. Method of Disposition Purlai 2 Cremation 3 R 4 Donation 5 Other (Specify)	emovel from State	Plece of Disposition (A cemetery, cremetory of BUTUS Ma	rother piece)	1 8/17/2	20c. Location - Ci	13 MM	inclan		
Depart Import any inj	21. Signature of Funeral Servica			end Address of Facility (REASTERS PLUS C. D. L.	THATHAN WWW RUM Z-1315	- Hams	Fuhen	el Home		
hysician	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea e ceuse on each line.	th. Do not enter the m	ode of dying, such es card	diac or respiratory arr	est,	Inten	roximate rval Between et end Death		
/Medical Examiner	Immediete Cause (Final disease or condition resulting in death)	PUST- OF	BSTRUCT	FIVE PNU	EMONIA		7	DAYS		
		Due to (or as a consequence of	i):			1			
lcian and burial-transit	Due to (or as a consequence of): PROIBABLE CENTIRAL MILAR MASS UNKNOV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury) Ceuse (Disease or injury) C.									
os the	resulting in death) Last		or as a consequenca o							
d for use	Part II. Other eigniftcant conditions con	tributing to death but not re-	sulting in the underlying	cause given in Part I	23b. Did to	obacco use conti	ribute to the	cause of death?		
ed by the	END STAG	•						4 Drunknown		
been s should	ANEMIA				24a. Was e perfor		evailable	utopsy findings e prior to tion of cause 1?		
page 2					1 🗆 Y	es 20 No	1 ☐ Yes	s 2 No		
director,	25. Was case referred to medical examiner?	ospital: 1 tnpatient 2	ER/Outpatient 3	Other:	Death (Check only or		(Specify)			
Affect fune	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred				
within 24 hours after deat Within 24 hours after deat To the Funeral Director: completely filled in by the Mardical Certifica	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy)		City or Tow		H			
within 24 hours after To the Funeral Dir completely filled in	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	tcian: To the best of my knower: On the basis of examino and manner stated.	owiedge, deeth occurre eti <i>on</i> and/or investigati	ed at the time, date end place on, in my opinion, deeth o	ace, and due to the o eccurred et the time, d	ause(s) and meni lete and place, en	ner es stated. Id due to the o	cause(s)		
To the	29b. Signature and title of cartifler	exports a	100	29c. License number D 2330	0	Pad. Date signed	ST 11	2000		
18:60	30. Name and address of person who con SUDH1R Description of the state	mpleted cause of deeth (Ite.	m 23a) (Type, Print)	Bon See	5T, 13	Sp.	nD. :	2/223		
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Sign	Spar Spar	6						

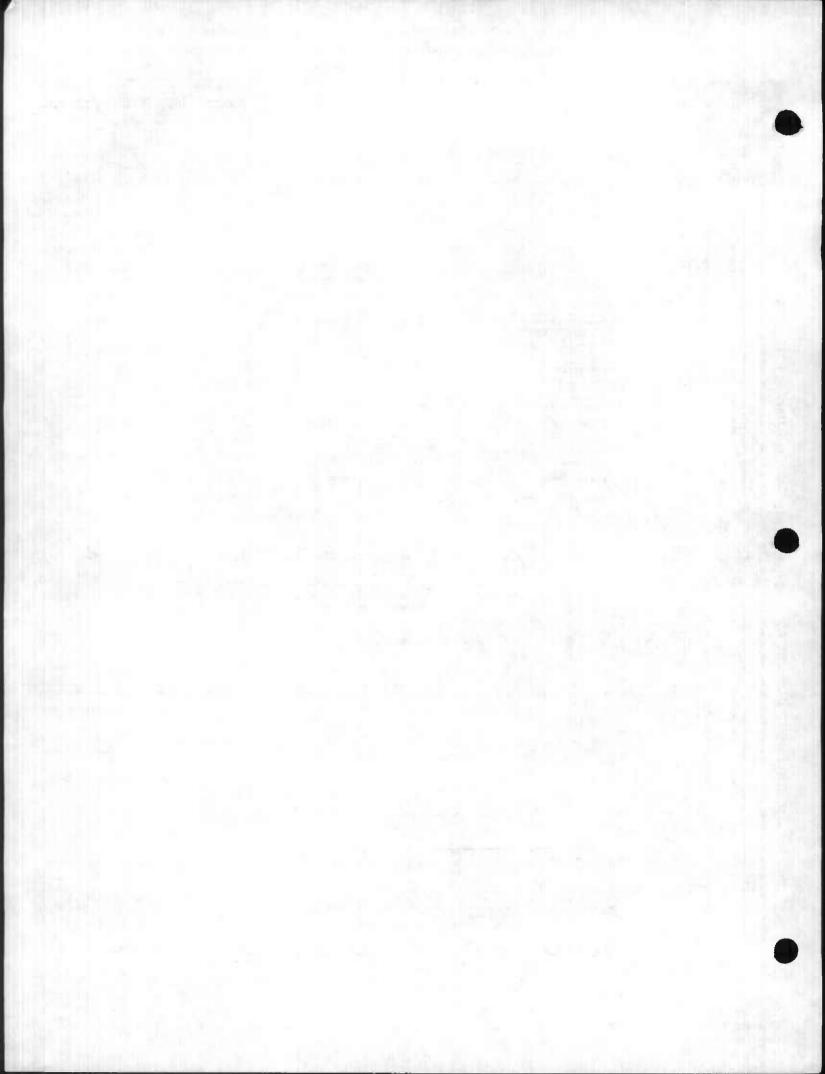


Amo	ended I	tem#28a per			W	Ce	rtificate	e of	Death		2. Data of D	Reg. No.		25380	
	iysician Medical	Dorothy Mar	RI C. LIGH								August	Day	2000°	4:29 P.M.	
	caminer	4a Facility Nama (If not institution, give street and number) 10523 Will-Mar Place							4b. City, To		cation of Dea		nty of Death		
_	neral ector	5. Social Security N 020-03-0849		.Sax 1□M 2□XF	1	yrs. last birthday Yrs.	If Under Months	1 Yaar Days		24 Hrs. Min.	8. Dafa of B March Z	Data of Birth Vall 9. Birthplace (State or F			
Maryland	fiedat	Usual Residence of 10a. State Maryland	10b. County	ore Co.	10	c. City, Town or L Cockeysvi						10d. Inside City Limits 1 □ Yes 2 🖔 No			
3s or 28s	LAIZID-DUZU ad within 72 hours after death with the Ma youn "nature!, or learn 23s or 28s+fs it the Medical Examiner must be notified Completed by Funeral Director	10e. Street and Nu 105 23 Wil-				10f. Zip		1030	1		10g. Citizen of What Country? United States of America				
020 urs after death		11. Marital Status 1 Never Mari	ried 2 Married	12. Was De Armed F 1 Yes If Yes, G Year or	Forces?	in U,S. 13.	Was Deced If Yas, spec	cify Cub	oan, Mexicen	igin? (Spe n, Puerto	ecify Yas or N Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc. Specify: White			
21215-0 d within 72 ho piene.		(Spe Elementary/Sect 12	Education grade completed College	(1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	rk done se retire	dunng mos	t of work	ing	Federal Govt.				
land life file fortal Hyg	To Be C	17. Fether's Neme Howard Jose			1111						ce Hinto	First, Middle, Maiden Sumame) e Hinton			
Battimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at opportunit of theath and Mental Hygiene.	or other traume		ce Howard sposition	Sullivan(2		osition (Nem	ne of	lace (Cocke		Marylan 20c. Location Baltim	d 210	030 Fown, Slate	
Baltin Permit P. Departme	any injury	4 Donation 21. Signature of Fi	5 ☐ Other (Special Lice)	**					ess of Facilit	y Ruc	k Towsor	Funeral Rd. Towso	Home,	Inc.	
Physic	oian	23a. Parni. Enter	the disease, or co art failure. List on	implications that ly one cause on	pacsad that	daath. Do not ar	tar tha mod	le of dy	ing, such as	cardiac	or respiratory	arresf,		Approximate Interval Between Onset and Death	
/Med	lical	Immediata Cause disease or conditi resulting In death)	on	a	YOU	ARDIA to (or as a conse	L 1	NF	=AR	CTI	01		. i	1 min.	
betr	Examiner			b. C	ORC	WAR	AG	2 To	ERY	D	ISEA	SE			
octificate be executing physician and	- E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua fo (or as a consequence of):													
O. Bc the death		Part II. Other significant conditions contributing to death but not resulting in the underlying cause						ause gi	iven in Part I	1.	23b. Did tobacco uss contribute to the cause			to the cause of death	
Cords, Frequires that	should										24a. Wa	s an autopsy formed?	24b. \	Were eutopsy findings available prior to completion of causa of death?	
I Rec	Page 2										1	Yes 2000		Yes 2000	
Vital Biclan: The certificate	Be	25. Was case refe axaminar?	rred to medicel	Massitel						e of Deat	h (Check only	one)			
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Division of or Attending after death.	led in by the funera Certification:	3 ☐ Suiclde 4 ☐ Homicide	6 Could not determine	200. Plac	ce of Injury ding, etc. (S	At home, farm, s pecify)	treet, factory	y, offica				(Street end Nu own, State)	m <i>ber or R</i> u	ral Route Number,	
DÍVÍSÍ To the Hospital or Attent within 24 hours after deat To the Funeral Director:	completely filled in by	29e. Certifier (Check only one)		aminer: On the		y knowledge, dee mination and/or i									
To the Within	Me	29b. Signatupo and	d fitle of cartifier	01101110			290	c. Licen	se number			29d. Dale sig		n, Day, Year)	

29c. License number 29d. Dale signed (*Month, Day, Year*) 8 · 15 · 00

30. Name and adjuss of person who completed cause of death (Item 23e) (Type, Print) 6569 N. CHARLES ST TOWSON

State Registrar 31. Date filed (Month, Day, Year) AUG 21 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 19, 2000 4:26 a.m. Oliver Albert Smith, Jr. 4a Facility Name (ff not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Raltimore Riverview Nursing Center Essex H Under 1 Yeer H Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 22, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1₩M 2□F Pennsylvania 69 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Essex 1 ☐ Yas 2 No 10f. Zip Code 10a. Citizen of What Country? 21221 U.S.A. 1415 Strawflower, Apartment B 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No 1948— If Yes, Give Year or Dates: 1952 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Packer Meat Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Gladys Gertrude Hughes Oliver A. Smith, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Strawflower, Apt. B, Baltimotre, Maryland 21221 Ruth Elnora Smith (wife) 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) 8/21/2000 Baltimore, Maryland GreenMount Crematory 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21 Signature of Seneral Selvice Line 1407 Old Eastern Avenue, Essex, Maryland 21221 finiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Due to (or as a consequenca of): Due to (or es a consequence of):

Physician /Medical Examiner

as the

158

page 2 should be detached

Be Completed by

Certification: To

Medicai

signed by

this certificate has

i or Attending Physician: after death. after death.

Director: After this certific
J in by the funeral director,

To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

or flams 25s or 25s-f show

Baltimore, Maryland 21215-0020

filed within

Pages 1 and 2 should be to ment of Health and Mental H tant: If them 27 is marked off

Department of Health Important: If New 27

the Medical Examiner must be notified

Directo

Funeral

þ

Completed

5. Social Security Number

216-24-1023

10e. Street and Number

5

20a Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

10a. State

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed' 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred

28b. Time of 28c. Injury at Work? 1 Yes 2 No

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident 3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

5 Pending

Investigation

6 Could not be

29c. License number D43725 29d. Date signed (Month, Day, Year) 8/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

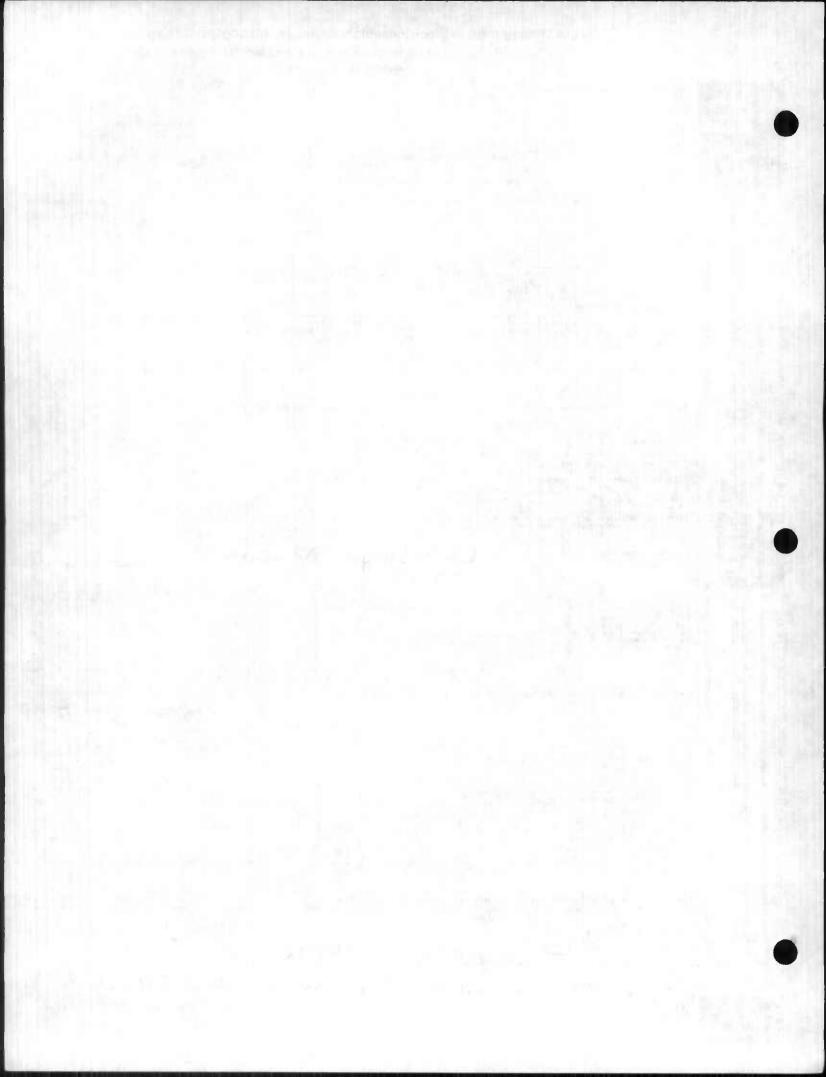
MD 21221 Back River Neck Rd Baltimore 201-109 TARIG MAITMOUD

Registrar

AUG 2 1 2000 32. Registrar's Signature

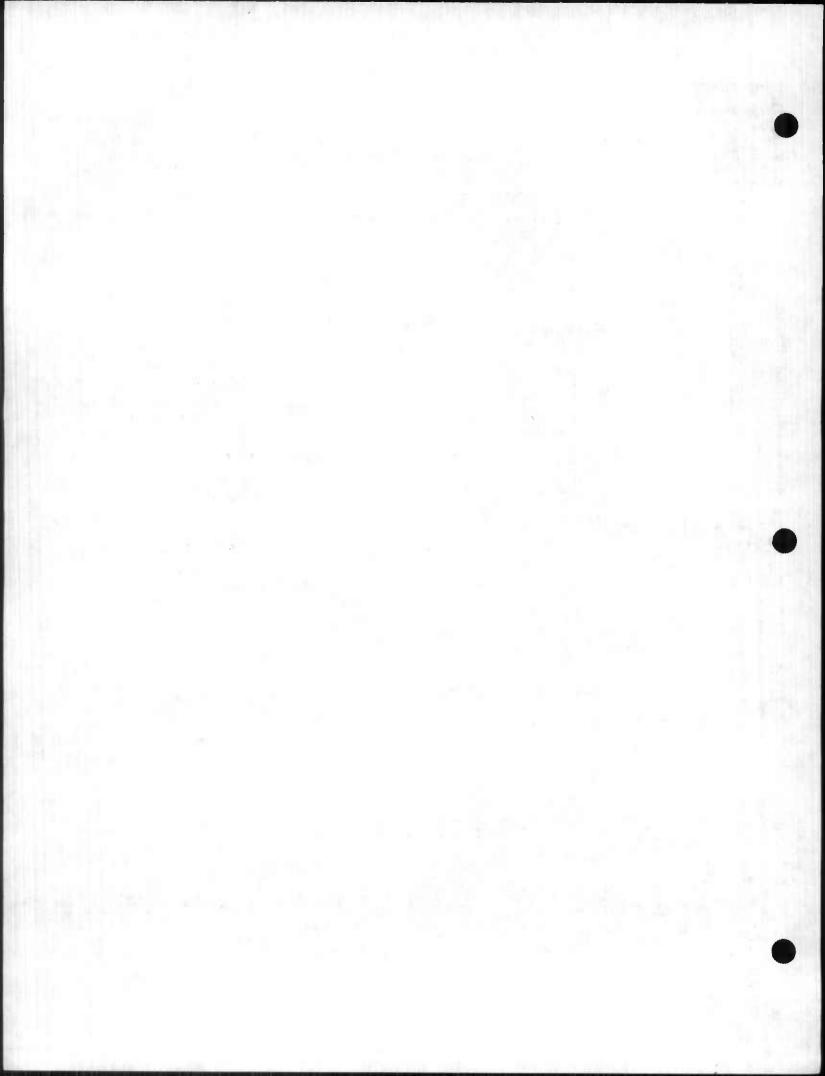
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amend item 30 per dvr G786 8/21/00 State of Maryland / Department of Health and Mental Hygiene 00 26382

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	1. Decedent's Nama (First, Middle, La	ist)					2. Date of Deat	h		. Tima of Death	
Physician	Virginia Som		Month 08	Dey Year 16 2000 2:2:		2:25 PM					
/Medical	4a Facility Name (If not institution, git		LCI		4b. City. To	own, or Lo	cation of Deeth	4c. County		2.25 IH	
Examiner	Broadmead	o ou out on a manipory									
				If Under 1 Y		eysv:			ltimor		
Funeral		Sex 7. Age (In yrs. last birthdey		eys Hours	Min.	8. Data of Birth (Month, Dey, Aug. 28	Year)	9. Birthplace Country)	(Stete or Foreign	
Director	216-10-7325		87 Yrs.				Aug. 28	, 1912	Maryl	and	
P .	Usual Residence of Decedani 10a. State 10b. County 10c. City, Town or Location 10										
ahou a	10a. State 10b. County				Inside City Limits						
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vith the Ma or 28s-f a be notified	10e. Street and Number 10f. Zip Code							0g. Citizen of W	hat Country?		
th with	13801 York Road 21030							U.S.A.			
of iter death with the Maryland r tems 23e or 28e-f show free must be notified at Funeral Director	11. Maritel Stetus	12. Wes Decedent Ev	er in U.S. 13	. Was Decedent		rigin? (Spe	ecify Yas or No-		- American I	ndian,	
	1 ☐ Navar Marriad 2 ☐ Married	Armed Forces? 1 ☐ Yas 2X No		If Yas, specify	Cuben, Mexica	n, Puerto	Rican, atc.)	Blech	c, Whita, etc.		
D20 urs at by F	3€ Widowed 4 Divorced	If Yes, Give Year or Datas:		1 ☐ Yes 2 ☐	No Specify.	:		Specify:	White		
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and 2 and 2	Mrs. Helen Seidl	er/Daughter	6108	Maiden	Lane B	ethes	sda, Mar	yland 2	0817		
other tr	20e. Method of Disposition		20b. Plece of Disa	position (Neme o	of	1		20c. Location -		State	
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S	shock, or haart failura. List only						0.0		On	ervel Between iset and Death	
Physician / /Medical	Immediate Course (Final	ne	Joca	0 -	01	2	Pare.	el . r		240	
Examiner	Immediata Ceuse (Final disaese or condition resulting in death)	/ run	joca	rais	20	27	reci -	par	1	D/1/C	
100	resulting in death)	19	ue to (or as e cons	equence of):		18					
P = 0	The state of the s								1		
cate be executed physician and sthe bunistransit	Sequentieily list conditions,	Di	ua to (or es a conse	equence of):							
E Paris	if eny, leading to immediate cause. Enter Underlying										
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Of Vital I Physicien: The ribis certificate ral director, par it To Be Co	25. Wes case referred to medical exeminer?				- 1	e of Deet	h (Check only on	(8)			
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O C G Ph G Ph neral nera	27. Menner of Death	28a. Date of Injury (Month, Day)	Year) 28b. Time	of 28c.	Injury et Work?		28d. Describe ho	ow injury occurr	ed		
ision wending deeth. ctor: Atter y the fune	1 Natural 5 Pending invastigation			М	1 Yes 2] No					
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ert Drage	4 Homicida	building, etc.	(Specify)				City or Town	n, Stete)			
DIVIS To the Hospital or Attawithin 24 hours after de To the Funeral Directo completely filled in by the	29e. Certifier 10 errifying Pl	nysician: To the best of	my knowledge des	th occurred at the	ne time date o	nd place	and due to the or	ausa(s) and ma	nner as elate	ıd	
he Hospil in 24 hou he Funeri pletsly fill edical		miner: On the basis of e	xeminetion and/or l								
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10	1 Jans	aw w		10	226	3	/	0/16	100	•	
000-1	30. Nama and address of person who	completed cause of dea	ih (Item 23a) (Type	, Print)							
OB	Broadmead Nursing Ho	me 13801 York	Road Cocke	ysville,	Maryland	2103	0				
	31. Date filed (Month, Day, Year)	32. Registrer									
State	ALIC 0 1 2000	he was 1	4 loo	1/2							



State of Maryland / Department of Health and Mental Hygiene
AMEND ITEMS: #23 PART I, 27 PER MEO Certificate of Death

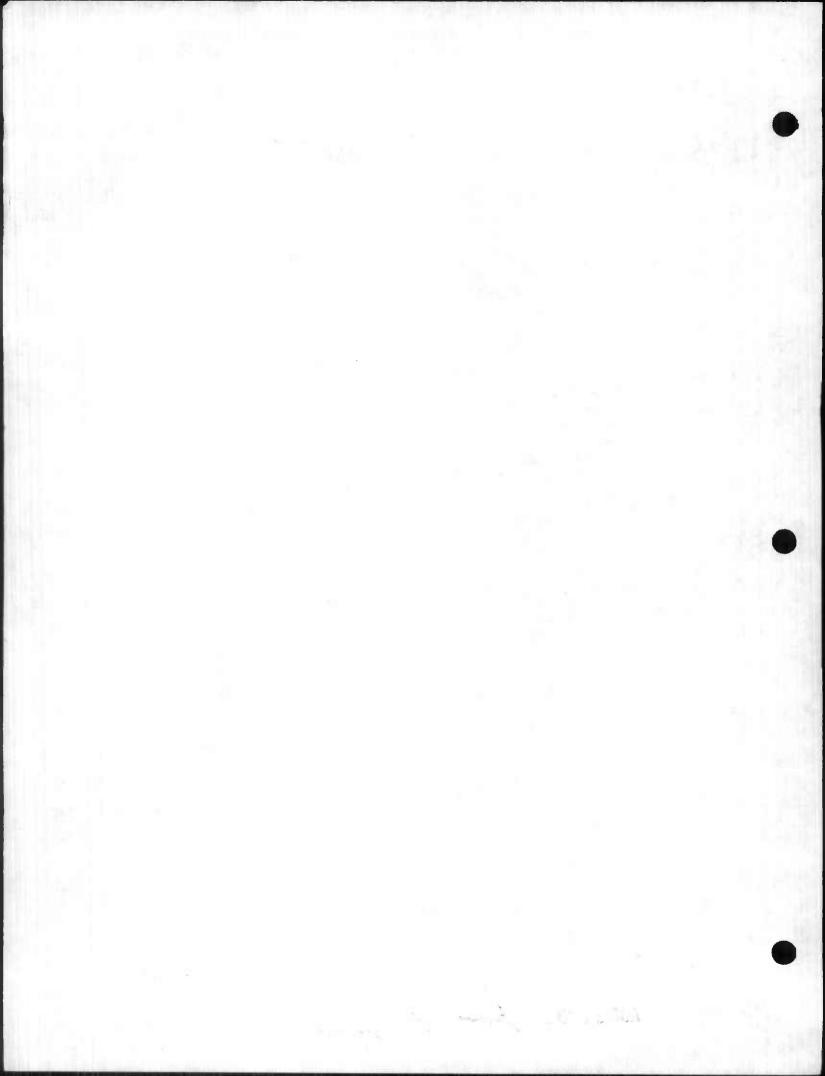
Beg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 18, 2000 John Steven Svehla 01:25 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/B JONES FALLS EXPRESSWAY PRIOR TO 695 BALTIMORE RUXTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 12 M 2 F Yrs. 217-02-5280 Director March 13 1969 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show name be notified at 1 TYas 2 No Baltimore Cockeysville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 10606 Partridge Ln. #A2 21030 USA Funeral nd 2 should be filed within 72 hours efter death the and Mental Hygiene.
27 I a marked other than "natural", or kema 23 treumatic event, the Lagorian manual event, the Lagorian and the contraction of the 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify White Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Liquor Distributor +4 Sales Manager 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John James Svehla Susan Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is in any Injury or other treun DRICE. Mr. John J. Svehla/ Father 3546 Anderson Ln. Jarretsville, Md. 21084 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cemetery 8-22-00 4 Donation 5 Other (Specify) Overlea. Md. 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc 23a. Part1. Enter the disease of complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 1050 York Rd. Towson, Md. 21204 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) SUBARACHNOID HEMORRHAGE Examiner Dua to (or as a consequence ot) Physician/Medical Examiner The law requires that the death certificate be executed use es the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Bnd Due to (or as a consequence ot): Box 68760. Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed Dage 2 : 2 No or Attending Physician: funeral director, 25. Was case referred to medical axeminar? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 Yes 2 No After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation death. 1 Yes 2 No 2 Accident after death the 28t. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sig ature and title of certific O.C.M.E. AUGUST 18,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street, Baltimore, Maryland 21201 DCKE, MU (No

State Registrar 31. Date tiled (Month, Day, Year) AUG 2 1 2000

32. Registrar's Signature Sparker



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item# 8 perDVRG787 9/1/2000 EW State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#23a per FD C786 8-21-00 WJJ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death SANDLER Month **Physician** EDIE 9:42am August 12,2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Paltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Days Hours 10M 20F Yrs. FEB 21- 1912 88-Director 214-03-6378
Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes XX No BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Nems 23s or munt be U.S.A. 21209 6605 LINCO AVENUE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status than "natural", or item the Medical Examiner. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1☐ Yes 2√ No Specify: WHITE À 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondery (0-12) Coltege (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) is marked RABINOWITZ BERNARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2714 WILLOW GLEN DRIVE, BALTIMORE, ND. 21209 19a. Informant's Name/Relationship (Type, Print) BERNARDINE GORDON/DAUGHTER If Health Hern 27 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation Removal from State 4 Donetion 5 Other (Specify) Pages FRIEDEL MARYLAND LODGE 8/13/00 ROSEDALE, MD. 22. Name and Address of Facility 21. Signature of Bu SOL LEVINSON & BROS. INC 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical Kesbirelm Examiner Due to (or as a consequence of) Aspiration Pneumonia Physician/Medical Examin Sequentially tist conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): attending physician end for use es the burial-trar Division of Vital Records, P.O. Box 68760, certificate be Due to (or as a consequence of): The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detact 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were sutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed after death.

Director: After this certificate has d in by the funeral director, page 2: 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case reterred to medicat 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

10

State Registrar

AUG 2 1 2000

DR USEROI 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

B Aparks

GROVE. 6701 N. Clarker St BDITO 21204

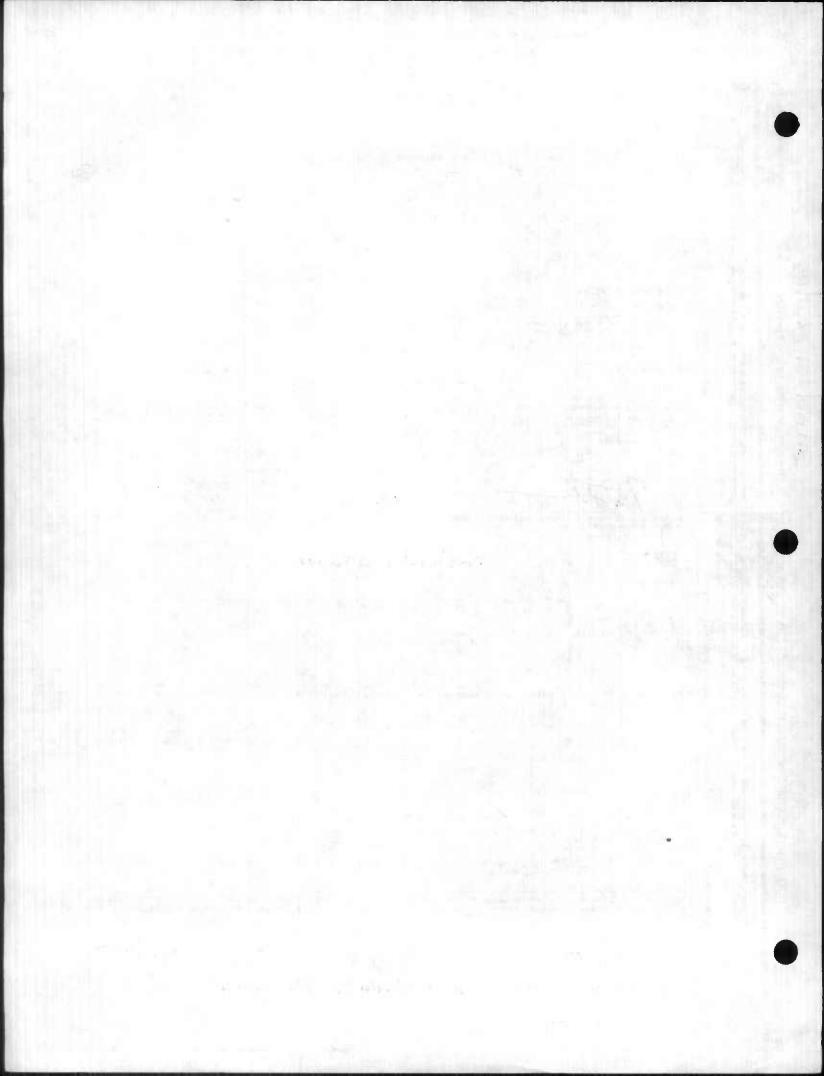
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Registrar

31. Data filed (Month, Day, Year)

TRAMBLE

NAME: BEN

ORIGINAL

32. Registrar's Signeture

AUG 1 8 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST 18 2000 FLORENCE STOUT WALTON 12:35 P.M. 4e Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD 5. Social Security Numbe 200-10-7713 If Under 1 Year 7. Age (In yrs. last birthday) 85 Yrs. If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Sex 1□M 2XF Days Months 02/02/1915 Pennsylvania Usual Rasidence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Idlewild St. Apt 1B 21014 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Bleck White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Memied 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George I. Stout Florence E. Garber 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Harrison Daughter 109 E. Ring Factory Rd. Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from Stata 4 Donetion 5 Other (Specify) Chesapeake Crematory 8/21 Beltsville, Maryland 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 21. Signeture of Furteral Service Licensee 2134 Willow Spring Road Dundalk, MD 21222 23a. Part1. Enter the distriction of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death tmmediete Cause (Final end stage demente disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown arten desta 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Directo

Funeral

Be

Funeral

Director

'natural', or flems 23s or 28s-f show

Hygiene.

pemit. Pages 1 and 2 should be filed. Dopartment of Health and Mental Hypit Important. If item 27 is marked other: any injury or other traumatic event, II

altimore. Maryland 21215-0020

Examiner Physician/Medical þ Completed Be Certification: To

edical

that the death certificate be executed physician and s the bunal-trans signed by t certificate or Attending Physician: director, After n 24 hours after death.

Ne Funeral Director: A natable filled in by the f death.

Box 68760 Records, P.O. Division of Vital

State Registrar **DHMH 16 Rev 6/95**

Hospital

To the Hosp within 24 hos To the Fune completely fi

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pleca, end due to the cause(s) and manner stated.

D32299

29c. License number

29d. Date signed (Month, Day, Year) august 18,2000

30. Nama and address of person who completed cause of death (flem 23a) (Type, Print)

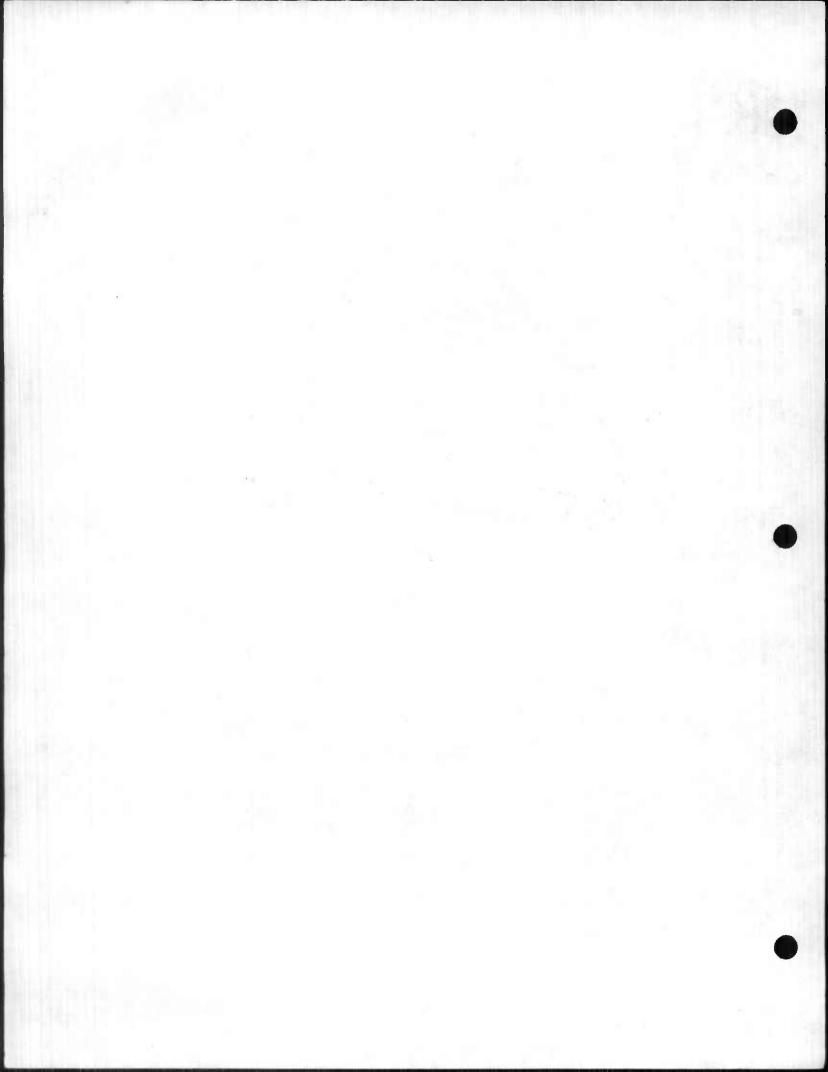
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31. Date filed (Month, Day, Year)

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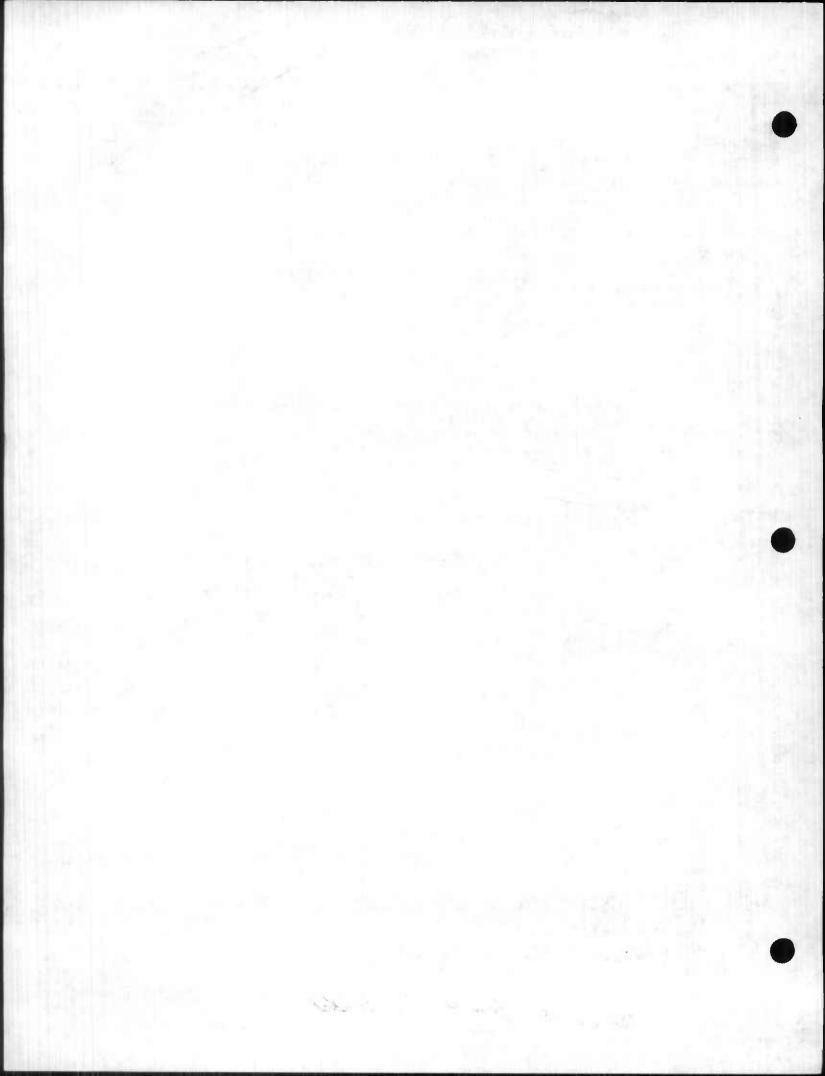
32. Registrar's Signature boaks



State of Maryland / Department of Health and Mental Hygiene

	C	ertificate of Death	Reg. No.	26387					
	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Ye	3. Time of Death					
Physician /Medical	Carroll J. Woodruff		August 20, 2000	12:30 A.M.					
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or L	ocation of Death 4c. County of D	eath					
WELL .	7539 Westfield Road	Dundalk If Under 1 Year If Under 24 Hrs.	Baltin						
Funeral Director	5. Social Security Number 246-38-8647 6. Sex 1 M 2 F 7. Age (In yrs. last birthde Yrs.	8. Date of Birth (Month, Day, Year) Aug 11, 1930	Birthplace (State or Foreign Country) NC						
9 k.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		10d. Inside City Limits						
with the Maryla a or 28e-f ahov be notified at Director	MD Baltimore Dundall	,		1 ☐ Yes 2 🔀 No					
or 28ers be notified Directo	10e. Street and Number	10f. Zip Code	10g. Citizen of What	10g. Citizen of What Country?					
A STAN OF THE OF T	7539 Westfield Road	21222	USA						
har death in the d		3. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto		merican Indian, /hite, etc.					
by by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1951-52	1 ☐ Yes 2 🕾 No Specify:	Specify:	Mite					
5-C 72 h matu fisal fisal	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of work	16b. Kind of Busine	ess/Industry					
1 21215-0 ed within 72 ho ygient. we than "natur rt, the Medical. Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work b. DO NOT use retired)							
- 8755 0	12 U Do	ock Worker	Freight ne (First, Middle, Maiden Sumame)						
land land to the file sental Hy sed of the covered	Lee Woodruff								
Maryl d 2 should h and Me 7 is ments ments ments ments		Hattie I ailing Address (Street and Number or Ru		te Zin Code)					
Mag de de de de de de de de de de de de de		9 Westfield Road,							
Te, 11 ar 11	20a Method of Disposition 20b. Place of Dis	sposition (Name of	Date 20c. Location - City						
Baltimore semit. Pages 1 appartment of He mportant. If Nen iny Injury or oth notes.	1 M Burial 2 Li Cremation 3 Li Hemoval from State	rematory or other place)	8-22-00 Baltimore	MD					
in party a	21. Signature of Europe Special Common	ary Cemetery 22. Name and Address of Facility	0-22-00 ballmole	, PID					
B Page 1	100	Cyach/Rosedale F	uneral Home	01007					
	23a. Part1. Enter the disease, or complications that caused tha death. Do not shock, or heart failure. List only one cause on each line.	1211 Chesaco Avenu enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between					
Physician	snock, or neart failure. List only one cause on each line.		0.	Onset and Death					
/Medical	Immediate Cause (Final disease or condition	Her D	Value						
Examiner	resulting in death) a. Due to (or as a con.	sequenca of):	Vailue Deserre						
P = 5	Corray	arten 6	destore						
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be ex cian burial burial									
68760, ficate be expression is the burial Edical E	that initiated events resulting in death) Last Dui to (or as a cons	sequence of):							
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y Py			1 Yee 20 No 3 Probably 4 Unknown						
				4b. Were autopsy findings available prior to					
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The law requir rate has been signage 2 should Completed			1 Ves No	1 □ Yes ANO					
Vital I sician: The certificate lirector, pag o Be Co	25. Was case referred to medical	26. Place of Dea	ith (Check only one)						
	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpa	Other:	. A	Specify)					
	27. Manner of Duan 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how injury occurred						
Division o To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation	M 1 Yes 2 No							
Divisio or Attendi after deeth. Director: A f in by the ft	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, building, etc. (Specify)	street, factory, offica	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,					
Dis after all Direction Cent									
To the Hospital within 24 hours To the Funeral I completely filled	29a. Certifier Certifying Physician: To the best of my knowledge, de (Check only Medical Examiner: On the basis of examination and/or								
the the mple	and manner stated.	_29c. License number	29d. Date signed (A	Moth Day Year)					
5 × 5 8	29b Signature and title of certifier	D / P ?	200. 000 5101100 (1)	00					
, (The wally w	W2007	3						
(0	30. Name and address of person who completed cause of dead (flam 23a) (Typ	on, Print)	91000						
	Taul VAILE 1576 Mer	117,10100	11020						
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ann W. I							

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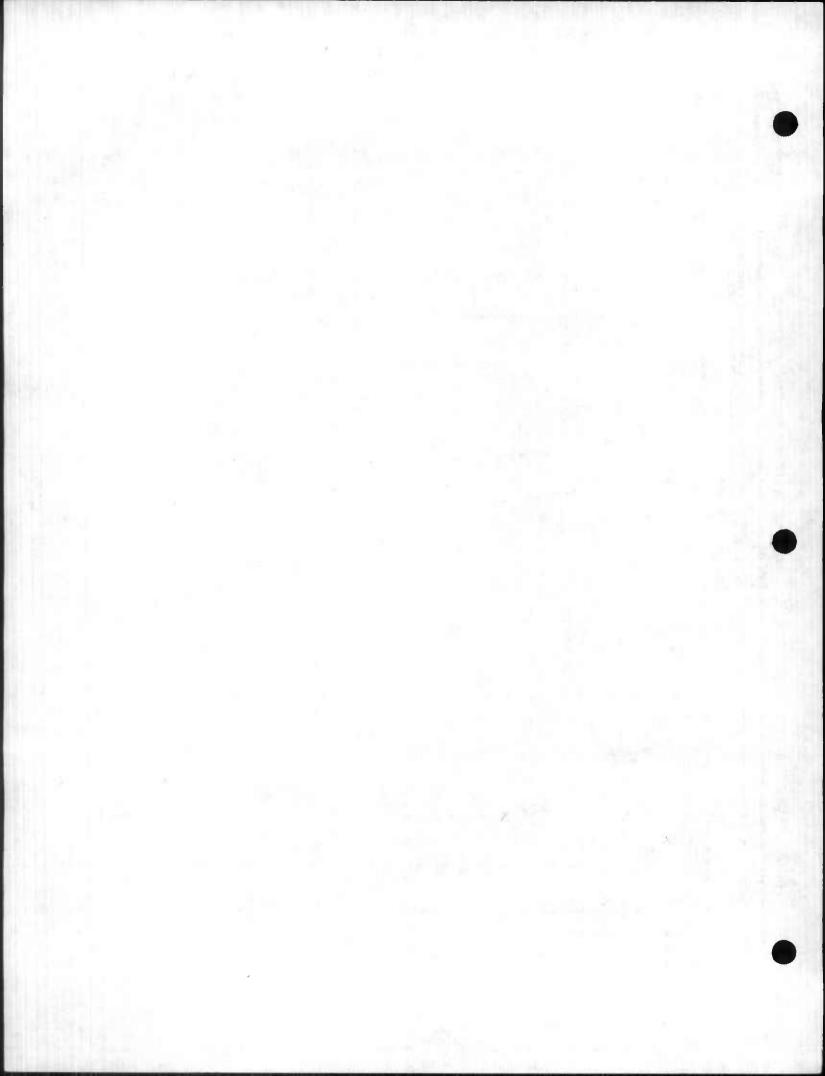


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUMUST Pay . 2 MASTER 9:30 AM Gerald Alwyn Wade /Medical 4a Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City_Town, or Location of Death 4c. County of Death i more Examiner Center OWSON If Under 1 Year If Undar 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Year) March 12, 1931 Michigan 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** XXM 20F Yrs. 369-30-6453 69 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland Baltimore 1 Yas 2X No Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 238 202 Long Cove Lane 21221 U.S.A. Funeral Нете 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 XYas 2 No 1950— If Yes, Give Year or Dates: 1954 Pages 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married ò Baltimore, Maryland 21215-0020 1 Yas 2000 Specify: ρ Specify: White 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Agent Steam Ship Line lith and Mental Hygie 27 is marked other in traumatic event, in 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Joseph Wade Gladys Unk. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health at Important: if item 27 is any injury or other trace 202 Long Cove Lane, Baltimore, Maryland 21221 Gloria E. Wade (wife) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/23/2000 Green Mount Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Experel Stavice Licenses 22. Name and Address of Facility Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Betw Onsat and Death **Physician** ISCHEMIC CARDIOMYOPATHY Immediate Causa (Final disease or condition resulting in deeth) /Medical Examiner CORONARY ARTERY DISEASE Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last use as the buriel-tran Due to (or as a consequence of): Box 68760. Due to (or as a consequenca of) the attending for P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE þ of Vital Records. 2 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Medical Certification: To Be Completed page 2 should PERIPHERAL VASCULAR DISEASE hes 1□ Yes 2 No 1 ☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) After this 27. Menner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicida 28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the To the To the 29b. Signature and title of continu 29c. License number 29d. Date signed (Month, Day, Year) D 37254 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BOON P. LIM, M. D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signeture Registrar AUG 2 2000 oorks

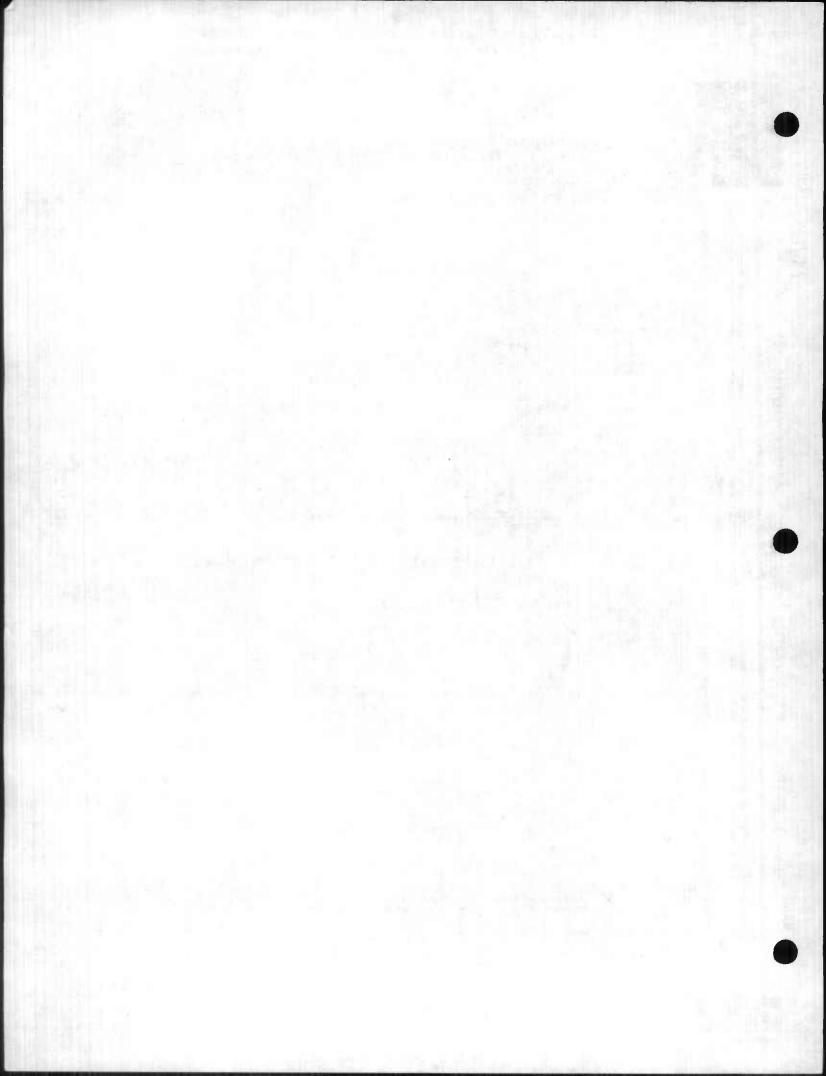


State of Maryland / Department of Health and Mental Hygiene

26389 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 07:10 PM Milton H. Wills, Sr. August 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Agnes Hospital Baltimore
If Under 24 Hrs. 8. Da N/A If Under 1 Year 8. Date of Birth (Month, Day, Year) April 4, 1 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 10 M 20 F 213-46-4707 Yrs. 1909 Maryland Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Catonsville Directo Baltimore 10g. Citizen of What Counfry? 10a, Streef and Number 10f. Zip Code 8 U.S.A. 21228 238 412 Montemar Ave. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Detea: Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whife, etc. 11. Marital Status 1 Never Married 2 Merried ŏ Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No å 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fireman Baltimore City 8 organization of and 2 should be the important: If them 27 is marked that any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Anna Schmidt Milton W. Wills 19a. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, MD. 21228 412 Montemar Ave. Milton H. Wills, Jr. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Placa of Disposition (Name of Jerusalem Lutheran Church Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-21-00 Baltimore, MD. 4 ☐ Dogation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pulmonary ed edema or embolism Examiner Physician/Medicai Examiner sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) certificate be execu renal failure 68760. Due to (or as a consequenca of) Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings svailable prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification prompletely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yea 2 No Medical Certification: To 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dev. Year) 29b. Signature and fittle of certifier 29c. License number D0053514 00. M.D. August 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOU, M.D. St. Agnes Hwan - Y .-31. Date filed (Month, Day, Year) AUG 2 1 32. Registrar's Signature Deper-Registrar

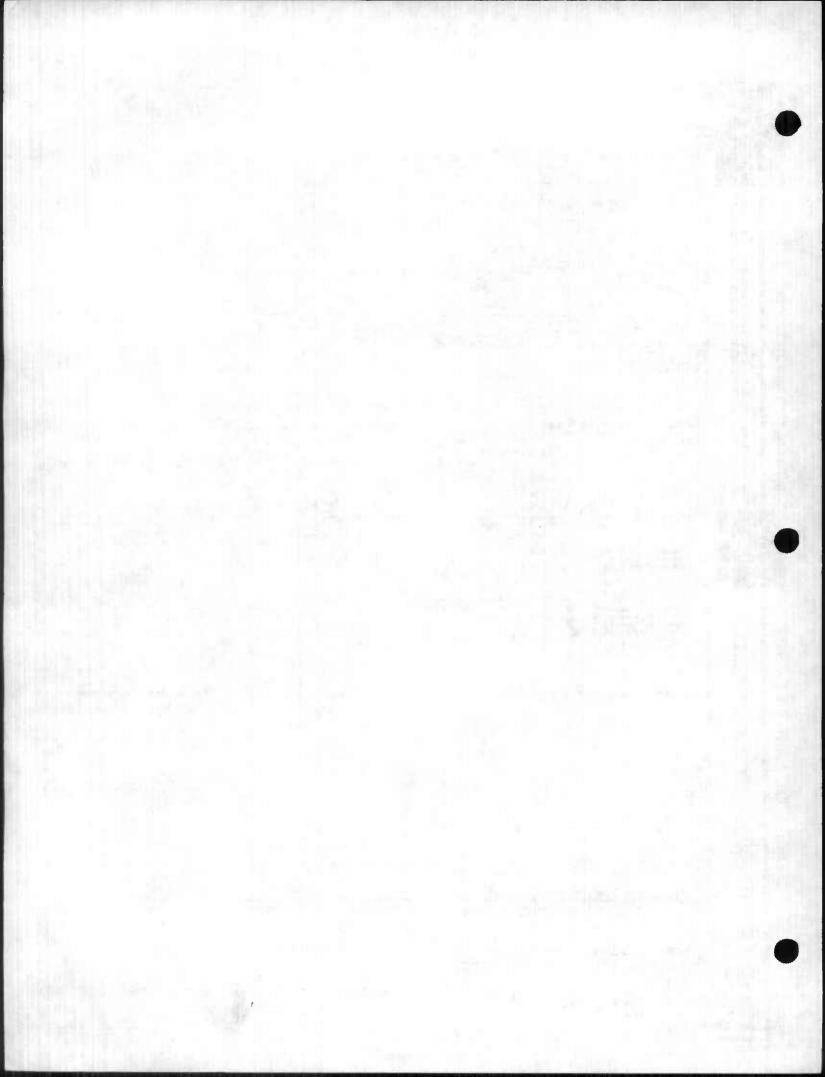


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Dey **Physician** 18-) orother. M. Willia 45 2000 AM AUG /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** medical BALTO NA Cester OF 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 10 M 30 F Days Min. 217-22 - 2464 Yrs. Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show NA 18 Yes 2 No MD Director BALTIMORE Hygiene, other than "natural", or itams 23e or other than "natural", or itams 23e or other went, the Medical Exemples must be notific 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bradford. ST. 21724 U.S.A 36 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important if flam 27 is marked other any injury or other treaming other. 14. Reca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WhITE p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home 12+4 NA tomemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be PORGE GrovES NI 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PECORA BALto MI) 21224 FAYEL MARGARET 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete → Burial 2 □ Cremation 3 □ Removal from State 21 140 OAKLAWN Cemeter 00 4 Donation 5 Other (Specify) 22. Name and Address of Facility HARTLEY Miller 21. Signature of Funerel Service Licensee CHTD Home Funeral HARFORD - BD. BALto. 21234 7527 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Betw Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical BOWEL IscHEMIA Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): as the bunal-trar Division of Vital Records, P.O. Box 68760, attending physician Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of ceuse of death? Completed 24e. Wes an autopsy performed? page 2 should this certificate has 2 KNd 1 Yes 1 Yes 2 No or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 DEPOSITION 2 ER/Outpetient 3 DOA 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred edical Certification: After Natural 2 Accident 5 Pending investigation after deeth.

Director: Aft
d in by the fur 1 Yes 2 No 6 Could not be 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospita 1 Sertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of Cortifier 29c. License number 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amer 4800 OUSE 31. Date filed (Months Day Year) 32 Registrer's Signature

DHMH 16 Rev 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26391 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 18,2000 135AM St WOODLAND Tugu + RANCES 5. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location & Death Amore If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Months Devs Hours 10 M 200 73 220 20 5832 4,1927 Vicgirla Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BA/ HIMURE Tes 2 No Maylore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1200 DRUID HILL AUG USB 21217 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2250 No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Black 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Our Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaken 46AR 17. Father's Name (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumeme) Qumi CAUL Inckson WILLIAM 19a. tnformant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 2315 W. BALTIMUR STREET BALTIMOR, Ned 21223 WOODLAND KATRICE Grand Dought Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 20b. Place of Disposition (Name of cemetery, cremetory or other place) Owings Mills, Marylano Garnson Forest Veteras Canaday 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHA THAN - HANRE Feneral Evens 5240 REISTERS FOUND ROAD 21. Signature of Funeral Service Licenses 23a. Party Enter the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Intervel Between Onset and Death Immediata Cause (Final disease or condition resulting in death) Months Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

1 and 2 should be Health and Mental

Pages

Baltimore,

Box 68760,

P.O.

of Vital Records,

Division

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Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

28a-f

mant be n

the burial-transit and 080 page 2 should funeral director,

Physician/Medical Examiner by Completed Medical Certification: To Be

25. Wes case referred to medicat examiner?

10 Yas 2 No

27. Manner of Death

1 Naturat

The law requires that the death certificate be executed physician After this certificate has or Attending Physicien: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

State Registrar

5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 117 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (ttem 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32r Registre oaks AUG 1 9 2000

28c. Injury at Work?

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA

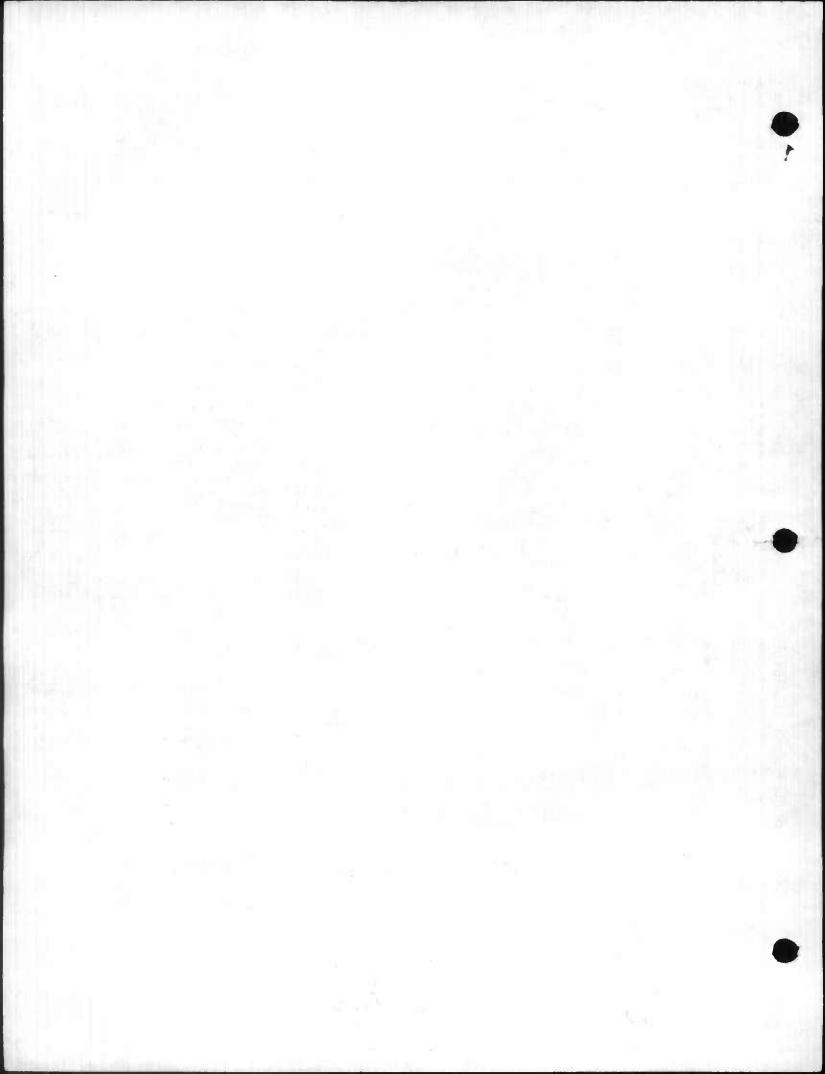
28b. Time of

28a. Date of tnjury (Month, Day Year)

26. Place of Death (Check only ona)

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

28d. Describe how injury occurred



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEMS: #10A,10C PER F.H. G789 State of Wallyland / Department of Health and Mental Hygiene Amend #18.Per F.H. PGC 8-4-2000 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Kober /Medical 4a Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Rochu R 3/ X Montgomery If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days M 2 F Months Hours 249 44 1408 Director 68 January17,1932S. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show WASHINGTON 10d. Inside City Limits Examiner must be notified at Director No Yes 2 No D.C. Washington D.C 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 234 3016 Nelson Place S.E. #2 20019 Funeral USA Hems. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married 1 XYes 2 No If Yes, Give netural, or 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Govt/Private 12th 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Surneme) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If them 27 Is marked or any Injury or other traumatic eve Henry Aiken Willie Mae Hadgood Hagood 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret Aiken/wife 3016 Nelson Place SE #2 Washington DC 20019 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 8-8-00 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Cem 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service License 4308 Suitland Road Suitland, 23a. Part1. Enter the disease, or complications that caused the cleath. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in deeth) Examiner 110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ung/ cancer Physician/Medical Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 ☐ Yee 2 ☐ No by 24b. Were autopsy lindings evailable prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 3 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 XNatural after death. Director: Aft 1 TYes 2 □ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number City or Town, Stele) 3 Suicide 4 | Homicide ò 29e. Certifier 1🗳 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated

21215-0020 Baltimore, Maryland P.O. 3 Probably 4 Unknown Records, Division of Vital 24 hours e Hospital Medical completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. within 2 To the £ 29b. Signature ei of contillation 29c. License number 29d. Date signed (Month, Day, Year) 0 10002 Washington Mospitr, Rm6B10, 110 Juny 8, NW Washington, DC cause of deeth (Item 23a) (Type, Print) OSHOW 32. Registrar's Signature 31. Date filed (Month, Day, Year, State AUG 0 4 2000

DHMH 16 Rev 6/95

Registrar

B.K.S

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

To Be Completed by Funeral Director 100 Per 10	sual Residence of Decedent a. State 10b. County MD be. Street and Number 522 Maude Avel Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highast) Elementary/Secondary (0-12) 11 7. Father's Name (First, Middle, Lame Michael Alley 9a. Informant's Name/Relationship	Que a street and number, INUE Sax Amage of the street and number, INUE 7. And INUE 12. Was Decedent Armed Forces' 1 Yes 2 Mil 1 Yas, Give Year or Dates: Education grade completed) College (1-4or	ge (In yrs. last bir 23 10c. City, Town Ba.:	thday) If Under 1 Yaar Months Days n or Location Ltimore 10f. Zip Code	4b. City, Town, or BALT IM If Under 24 Hrs. Hours Min. 2 2 5 tispanic Origin? (San, Mexican, Puarl	S. Date of Birth Month, Day Nov.	Og. Citizen of What GUSA	1424 PM birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 M Yes 2 No Country?		
aminer 4a aminer 4a 5.3 5.3 100 Store Production 100 100 100 100 100 100 100 100	Social Security Number 218-15-2955 Sual Residence of Decedent De. Street and Number 22 Maude Aver Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highast) Elementary/Secondary (0-12) 11 7 Father's Name (First, Middle, Lame Michael Alley 9a. Informant's Name/Relationship	RUE Sax NM 2 F 7. And TUE 12. Was Decedent Armed Forces' 1 Yes 2 M If Yas, Give Year or Dates: Education grade completed) College (1-4or	ge (In yrs. last bin 23 10c. City, Town Ba.	If Under 1 Yaar Months Days n or Location Ltimore 10f. Zip Code 21 13. Was Decedent of Hif Yes, specify Cubulling Yes, Specify Cubul	BALT'IM If Undar 24 Hrs. Hours Min. 2 2 5 Iispanic Origin? (San, Mexican, Puari	S. Date of Birth Month, Day Nov.	9. B 3, 1976	inthplace (State or Foreign Country) MD 10d. Inside City Limits 1 M Yes 2 No Country?		
To Be Completed by Funeral Director	sual Residence of Decedent a. State 10b. County MD be. Street and Number 522 Maude Avel Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highast) Elementary/Secondary (0-12) 11 7. Father's Name (First, Middle, Lame Michael Alley 9a. Informant's Name/Relationship	M 2 F 12. Was Decedent Armed Forces' 1 Yes, Give Year or Dates: Education grade completed) College (1-4or	23 10c. City, Town Ball Ever in U.S. No	Months Days n or Location Ltimore 101. Zip Code 21 13. Was Decadent of Hif Yes, specify Cuba 1 Yes 2 No	Hours Min. 225 Iispanic Origin? (San, Mexican, Puart	1	Og. Citizen of What OUSA	MD 10d. Inside City Limits 1 M Yes 2 □ No Country?		
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19	Michael Alley 9a. Informant's Name/Relationship	ist)		Carpenter	,		Carpent	cry		
19	9a. Informant's Name/Relationship				18. Mother's Nar	me (First, Middle, I				
19		Υ .	Karen	Miller						
K				. Mailing Address (Street			r, City or Town, State	o, Zip Code)		
1 - 5	Caren Alley/Mo	other		2 A Street	, Lothi		20711	7 0.4		
204	a. Method of Disposition 1 ☐ Burial 2 ☒ Cramation 3		camete	Disposition (Name of ry, crematory or other place politan C			Alex., \			
21	4 ☐ Donation 5 ☐ Other (Spe 1. Signature of Funeral Service) is		Metro	-	4 =					
	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Raymond—Wood F. H., PO Box 430, Dunkirk, MD 20754									
cal Examiner	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or Injury at initiated events soutling in death) Last	b	Due to (or as a	consequence of):	. AG					
Pai	art II. Other eignificant conditions	contributing to death t	out not resulting in	n the underlying cause given	ven in Part I.			ute to the cause of death		
Completed by F								b. Were autopsy findings available prior to completion of cause of death?		
a 25	5. Was case referred to medicat examiner?	Hoor's-1				ath (Check only or	ne)			
odical Certification: To	1 X'es 2 No 7. Manner of Death 1 Natural 5 Pending investiga 2 Accident 6 Could no determin	t be ed laca of m building, e	y rear) 28b. Juny - At home, fa	Time of Foundation Wo	Other: 4 Nursing Home 5 Residence 8 DOther (Specify) AT SCEN njury at Work? 1 Yes 2 No Subject haused Self					
29	9a. Certifier 1 Certifying (Check only one) 2 Medicat Ex	Physician: To the best	of my knowledge of examination an	dor investigation, in my d	me, date and place opinion, death occu	e, and due to the curred at the time, d	cause(s) and manner date and place, and c	as stated.		
-	b. Signature and title of certifier	/		29c. Licens	se number	2	29d. Date signed (Mo	onth, Day, Year)		
	1 a P	tanes	M	0.0	C.M.E		AUG. 5,	2000		
30		no completed cause of	death (Item 23a)	(Type, Print) Penn Street,	Baltimo	ore, Mary	land 2120	1		

ate of Maryland / Department of Health and Mental Hygiene Certificate of Death	00	1 0
Certificate of Death	U	2

	1. Decedent's Neme (First, Middle, Las					2. Date of De Month	Day	Year	ime of Death	
an al	PAUL DARREN					Augus			3:24 P.I	
er	4a Facility Name (If not institution, give	ocation of Deeth								
_	Frederick Me 5. Social Security Number 6. Se	-	yrs. last birthday)	If Under 1 Year	Frede			rederick		
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	10a. Stete 10b. County	10	c. City, Town or Lo	cation				10d. Ins	side City Limits	
to	Maryland Frederi			1X	Yes 2 No					
Director	10e. Street and Number		10g. Citizen of What Country?							
	1201 Maple Terrac		U.S.A.							
natic event, the Madical Estatement must be notified at To Be Completed by Funeral Director	11. Merital Stetus 1 Never Married 2 Merrled 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ▼ No	dispanto Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	o- 14. Raca - American Indian, Black, White, atc. Specify: White			
	15. Decedent's Ed	dent's Usual Occup	Dation	ing	16b. Kind of Business/Industry					
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	10		Conc	rete Fin				Concret	te Co.	
	17. Father's Neme (First, Middle, Last)		18. Mother's Nem			10)				
	Larry Wayne Boone	ima Bristi	10h 10-11	na Addrage (Chart	Arlyn Je			State 7in Code	1	
	19a. Informent's Neme/Reletionship (7) Terri R. Boone (W:				rrace Ln.					
	20a. Method of Disposition		Ob. Plece of Dispo cametery, cren			Date Date		City or Town, St		
	1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify,	Liamonal Itom State	cametery, cren Resthaven			/10/00	Frederi	ck, Mary	rland	
	21. Signature of Fune di Service Lipse	6.000	. / 22	. Name end Addre	ess of Fecility					
	× 9/1/0	Liles	RC RC	DBERT E.	DAILEÝ & AIN ST.,				A.	
Examiner	Immediate Cause (Final disease or condition resulting in death)	e. Head X	to (or as a conseq	quence of)	rea			 		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of):									
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an		23b. Did		ontribute to the o	ause of death					
y Sicilar	Part II. Other significant conditions co									
	Part II. Other significant conditions or					10	Yes 2 No			
2	Part II. Other significant conditions or					24a. Wes	an autopsy ormed?	24b. Were au available complete of death	prior to on of cause	
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o Be Completed by	25. Was case referred to medical avaminer?	Hospital: 1 ☐ Inpatient	2 ₩ ER/Outpatier	nt 3□ DOA Otl	hor	24a. Wes perfo	an autopsy ormed? Yes 2 \sum No	available complete of death	prior to on of cause ?	
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nvsician		me (First, Midd			TNC			2. Date of De	Dev	Year	3. Time of Death	
Physician /Medical	A. Fasilia Nama	JOHN	WALTER		LNG		4b. City, Town, or	AUGUST	5, 21	000	3:55 AM	
Examiner	STATE OF THE PARTY	The second	on, give street and nu rial Hosp				Frederi			rederi	ck	
neral ector	5. Social Security 040-26-4	Number 4067	6. Sex 1(XM 2□ F	7. Age (In yrs. last		If Under 1 Yeer Months Deys	If Under 24 Hrs Hours Min	8. Dete of Bir	th ly, Year)	9. Birthple	aca (State or Foreig cry) ecticut	
	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10	d. Inside City Limit	
ctor	MD Frederick Knoxville								1 ☐ Yes 2 🖔 No			
Funeral Director	10e. Street and No.		rive			10f. Zip Code 21758	3		10g. Citizen of What Country? USA			
by	3 ☐ Widowed	rried 2(2) Mer	rried 1 XYes		10	as Decedent of H 'es, specify Cubo Yes 2 XNo	tispanic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify: White			
tem 27 is marked other than "nature other traumatic avent, the Modest other traumatic avent, the Modest other traumatic avent, the Modest other	(Special Section 19)	ecify only highe	nt's Education est grade completed) College (6a. Deceder (Give kir life. DO Baker	nt's Usual Occur nd of work done NOT use retire	upation le during most of working red) 16b. Kind of Business/Industry Jefferson Pastr Jefferson, MD			stry Shop		
	17. Father's Neme		an Brunin	g				me (First, Middle ine Vero	, Maiden Surnan	10)		
	19e. Informent's I		ship <i>(Type, Print)</i> runing _s Wi	fe	628 Ti	ritapoe	end Number or R Drive s			Stete, Zip (Code)	
	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) St. Mary's Cemetery								Peters			
Important: any injury once.	22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Interval Between Interval Bet										21716	
		the diseese, o eert feilure. List			Do not enter		ng, such es cardia	c or respiretory e	rrest,		Approximete Interval Between Onset end Death	
aminer	disease or condition	ion	ACI	up In	NES	TINA	2150	Hem	IA		40h	
100	disease or condition resulting in deeth	ion)	ACI	CUPE IN DUE to (or as			2 150 45 CU	Hem	DISEY	tre	40h	
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The Function of After this certificate has been signed by the attending physician and plately filled in by the funeral director, page 2 should be detached for use as the bunki-transit plately filled in by the funeral director, page 2 should be detached for use as the bunki-transit plately filled in a function of the following plately plately filled from the following plately plately filled from the following plately plately filled from the function of the fu	Sequentially list of if any, leading to cause. Enter unc Cause (Disease of that initiated even resulting in death) Pert II. Other algn 25. Wes case refe examiner? 1 Yes 27. Manner of Det 1 Neturel 29. Accident 3 Suicide 4 Homicide 29a. Cartifier (Check only one) 29b. Signsture en	conditions, immediate derlying or injury liss) Last erred to medical services of Dendi invest of Could determ the condition of the conditio	d	Due to (or es Due to	VOutpatient b. Time of Injury e, ferm, stree	ance of): ance of):	26. Place of Dener: 4 Nursing ly at R? Yes 2 No	23b. Dld 1 24e. Wes performance ath (Check only) lome 5 Resi 28d. Describe 28t. Location (City or To	tobacco use co Yes 2 No an eutopsy ormed? Yes 2 No one) idence 6 Oth how injury occur Street and Numb wn, Stete) ceuse(s) and madate end place, 29d. Dete/signe	24b. We ave con of d	the cause of deat ably 4 Unknow re autopsy findings illeble prior to repletion of cause feath? I Yas 2 No Route Number, ated, the cause(s)	

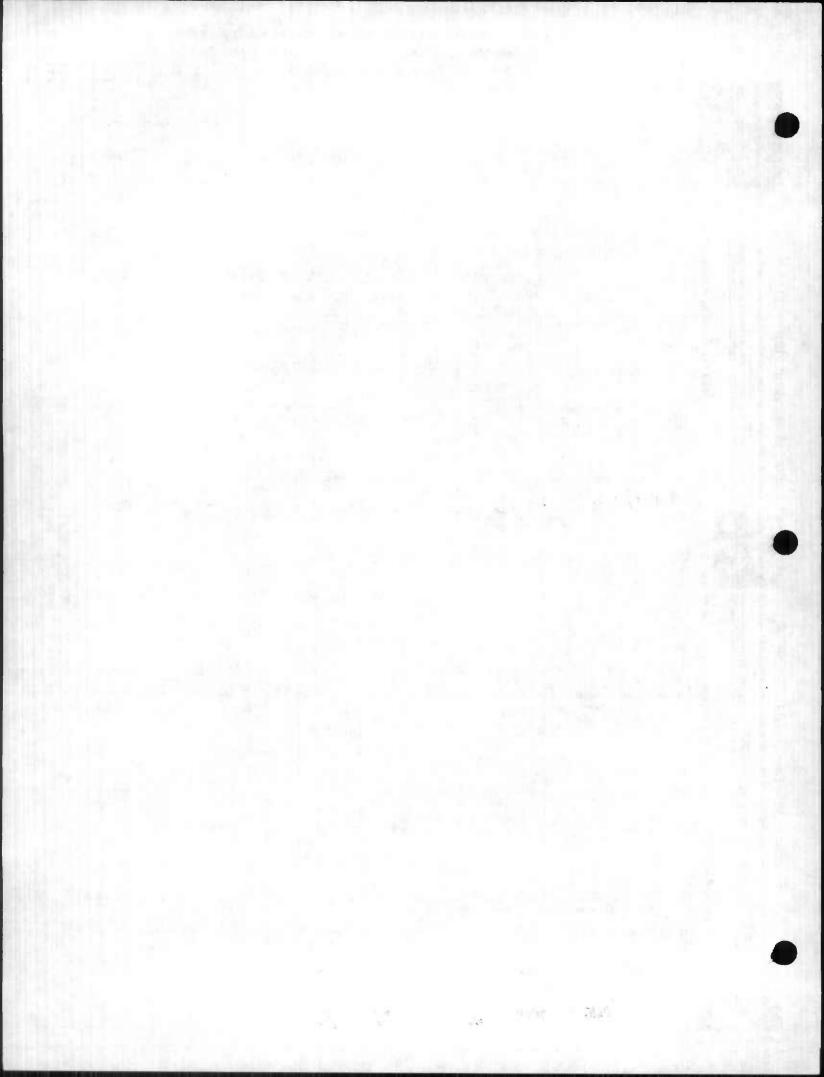
CILL BUSSIANON, WILL

Shoulder as the set of

symmetrical little and army liquids.

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No.	26396				
	Physician	1. Decedent's Neme (First, Middle, Lest) Ethel Caroline Beachley	2. Date of De	1, Dey 2000	Year 3. Tima of Death 10:47 PM				
2	/Medical		or Location of Death						
	Examiner	Northampton Manor Nursing Home Frede		Fred	erick				
	Funeral Director	212-38-7623 1UM 2QF 100 Yrs.	Irs. 8. Date of Birdin. Jan. 7	th 1900	9. Birthplace (State or Foreign Maryland				
	¥ 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
	ath with the Maryla s 23s or 28s-f sho mat be notified at sral Director	Maryland Frederick Frederick			1 O Yes 2 □ No				
		10e. Street and Number 409 Magnolia Avenue 10f. Zip Coda 21701		10g. Citizen of W					
21215-0020 si with 72 hours after deal sign. Then 'natural', or items The Medical Exercite or		11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1	(No specify: Specify: White						
5-0	72 h	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of the lifts. DO NOT use retired)	vorking	16b. Kind of Bu	siness/Industry				
212	ed within 72 ho ygiene, wer then "natura 4, the Medical. Completed	Elementary/Secondary (0-12) College (1-4or 5+) School Teacher		Board	of Education				
P	an Hyp d other event, I Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Middle,						
yla	Ments Ments arked arke			Carolin					
, Mar	and 2 sh salth and n 27 is m	19a. Informant's Name/Relationship (Type, Print) Miss Pamela F. Beachley, Niece 19b. Mailing Addrass (Street and Number of 469 Carrollton Driv	e, Freder	rick, Md	. 21701				
imore	Pages 1 mant of 14 ant: If the ury or off	20a. Method of Disposition 1	4, 2000	Middlet	own, Md.				
Balt	Dapart Import eny inj	21. Signature of Funeral Service Licensee MO0255 22. Name and Address of Facility Keeney and Basfo	ord P.A.	Funeral	Home Md. 21701				
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cere shock, or heart failure. List only one cause or leach line.	Jiac or respiratory a	rrest,	Approximata Interval Between				
	Physician // /Medical				1.				
3	Examiner	disease or condition resulting in death) Bue to (or see a consequence of):	Due to (or as a consequence of): Where clastic ardiovascular disease 20 years						
	D # D	- athers cherotic andion	zsaela	desease	e 20 years				
	erificate be executed ing physician and eas the burial-transit Medical Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury thet initiated events rasulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of):							
Вох	death cent e attendin ed for use siclan/N		L cou Bu						
P.0	ires that the death certific signed by the attending pd be deteched for use as dby Physician/Mee	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part f. Multiple SADALS	use given in Part f. 23b. Did tobecco use contribute to the cau 1 Yes 2 No 3 Probably						
Records,	been shoul			an autopsy ormed?	24b. Wara autopsy findings available prior to completion of ceuse of death?				
Re	iclen: The lay certificate hes rector, page 2 Be Comp		10	Yes 2 No	1 Yes 2 No				
/ita	entifica ector, Be C	examiner?	Death (Check only	ona)					
of	this aidi		g Home 5 ☐ Resi	dence 6 Other					
Lo	Attending in death. ctor: After by the fune	27. Manner Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Tima of Injury Work? 1 Accident investigation 28c. Injury at Work? 1 Yes 2 No							
Division of Vital	tal or Attending P is after death. al Director: After ted in by the funers Certification:	3 Suicide 4 Homicide 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Streat and Numb wn, State)	er or Rural Route Number,				
	24 hour 24 hour Eliner etaly fill dical	29a. Certifier 1 Certifying Physician: To the best of nry knowledge, death occurred at the time, data and pl (Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath of and manner stated.							
	To the To the comp	29c. Signature and filing of cogillier 29c. License number	22		d (Month, Day, Year)				
		Vali y apromitted D351	55	August	2, 2000				
		30. Name and address of person who completed cause of death (flegs 23e) (Type, Print) The result of the second se	2. Fre	ederic	L, MO				
	State Registrar	31. Outs filed (Month, Day Year) 32. Registrar's Signature	,						



					Certifica	te of	Death	F	leg. No.	26391
	61	1. Decedent's Nama (First, Midd	ile, Last)					2. Date of Dea Month	ith	3. Tima of Death
	Physician /Medical	Hettie		Bel1				August	,	2010
j	Examiner	4a Facility Name (If not institution					4b. City, Town, or L Clinton			of Death e George's
		Southern Mary 1 5. Social Security Number			et eta) If Linds	er 1 Year		8. Dete of Birth		
н	Funeral Director	217-46-4488	1 M 2 F	ge (In yrs. last bii 55	Yrs. Months			June 24	, Year) 1945	9. Birthplace (State or Foreign Country) Mary Land
1	D Res	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Tow	n or Location					10d. fnside City Limits
	t sho	Maryland Anne	Arundel		Shady S	Side				1 ☐ Yes 2 No
	an with the Marya 23e or 28e-f sho ust be notified at rai Director	10e. Street and Number				ip Code		1	I0g. Citizen of W	hat Country?
	al D	1310 Juniper	St.			2076	54		USA	
21215-0020	at, or hams Examiner in by Furner	11. Marital Status 1 Never Merried 2 Me 3 XWidowed 4 Divorce	If Vas Give	?			Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American Indian, s, Whita, etc. Black
2-0	feet in		nt's Education est grade completed)	16a	Decedent's Us	ual Occu	pation	ina	16b. Kind of Bus	siness/Industry
121	Man 'wan'		T	5+)	Manager		during most of work	9	Cafeter	ria
12	fygiens. her than nt, the Ma	17. Father's Neme (First, Middle	(age)		nanage		18. Mother's Nam	o /First Middle		
and	eve o	Calvert		Burley			Josephin			nnis
ary.	merks merks merks merks	19a. Informant's Neme/Relation			. Mailing Addres	s (Stree	t and Number or Rus		r, City or Town,	State, Zip Code)
× i	4 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Yolanda Bell/I	aughter	1:	310 Jun:	Lper	St. Shad	y Side,	MD 2076	4
ore	of to	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demousifred State	comete	f Disposition (No	ame of other pla	ice)	Date	20c. Location - 6	City or Town, Stata
altimore	ury o	4 Donation 5 Other (Lakemo	ont Mem	. Ga	rdens 8,	/11/00	Davidson	nville, MD
Balt	Depart Import any inj	21. Signature of Funerel Service	9. Sewel	0			ess of Facility Sev Beach Rd			ne ick, MD 20678
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause	d the deeth. Do	not enter the mo	de of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	hysician									Onset and Death
	/Medical Examiner	fmmediete Ceuse (Finel disease or condition resulting in death)	a. Massi	ve Iso	hemic	STAO	ke on R	Jeht ADI	asphere	days
	<u> </u>				consequence of					
1	n and ial-transit	Sequentially list conditions	b. MRS	Due to (or as a	consequence of	1:				days
68760,	physician and streets the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0301			,	Tape II			Sears
68760,	physicial streets the but edical	that initiated events resulting in death) Last	o Dias	Due to (or as e	Mallitus consequence of):	19 10x 11			1003
	0 0		End End	stage	Renas		disease			Years
. 1	d by the attendin etached for use.	Part II. Other significant condit	one contributing to death i	out not resulting l	n the underlying	cause d	iven in Part I.	23b. Dld t	obacco use con	tribute to the cause of death?
P.0	ed by the a detached		And Detail					101	res 2□No	3 Probably 4 Unknown
	b b d	TZ. WANTE	cargio milo:	pathy,	mens	1120	142			
Vital Records,	been shoul	6 MRSA	sopticemia	,	100			24a. Was o	en autopsy med?	24b. Were autopsy findings evailable prior to completion of cause of death?
I Re	page 2		1 (1)			3. 1.		101	es 25(No	1 ☐ Yas 2 ☐ No
ital	s certificate director, pag	25. Wes case referred to medic examiner?	a thirte	103.7	a so	-12.QV	26. Place of Dee		ne)	
of Vita	S O S	1 Yes 2 No	Hospitel: 1 🔀 Inpati		utpatient 3 🗆 🗀	NA			ence 6 Othe	
o uc	after death. Director: After this in by the funeral ertification:	27. Manner of Death 1 Natural 5 □ Pend		ay Year) 28b.	Time of Injury M	28c. Inju	ork?]Yes 2 □ No	28d. Describe h	ow injury occurr	ed
Division	after death. Director: A I in by the fu	3 Suicide 6 Could		jury - At home, fa				28f. Location (5	treet end Numbe	er or Rural Route Number,
S S	as of a section of	4 Homicide	building, e	c. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	m, State)	
Line Police	Funer tely fill		ng Physician: To the best f Examiner: On the basis of and manner s	of examinetion en						
- 4	within 2 To the comple	29b. Signature and title of certifi	er		2	9c. Licen	se number		29d. Date signed	(Month, Day, Year)
		Dote	il the a	220		1	000 1288	d	8	6007
د		30. Name and address of person	who completed cause of	death (Item 23e)	(Type, Print)		VV 1400	13		
8		PETER W. Tim		d Branch	ave si	rite 1	01. 01:	nton 1	marylan	d 20 735
	State Registrar	31. Date filed (Month, Day, Year	0 7 2000 N	Signature	· b.	4	mel			

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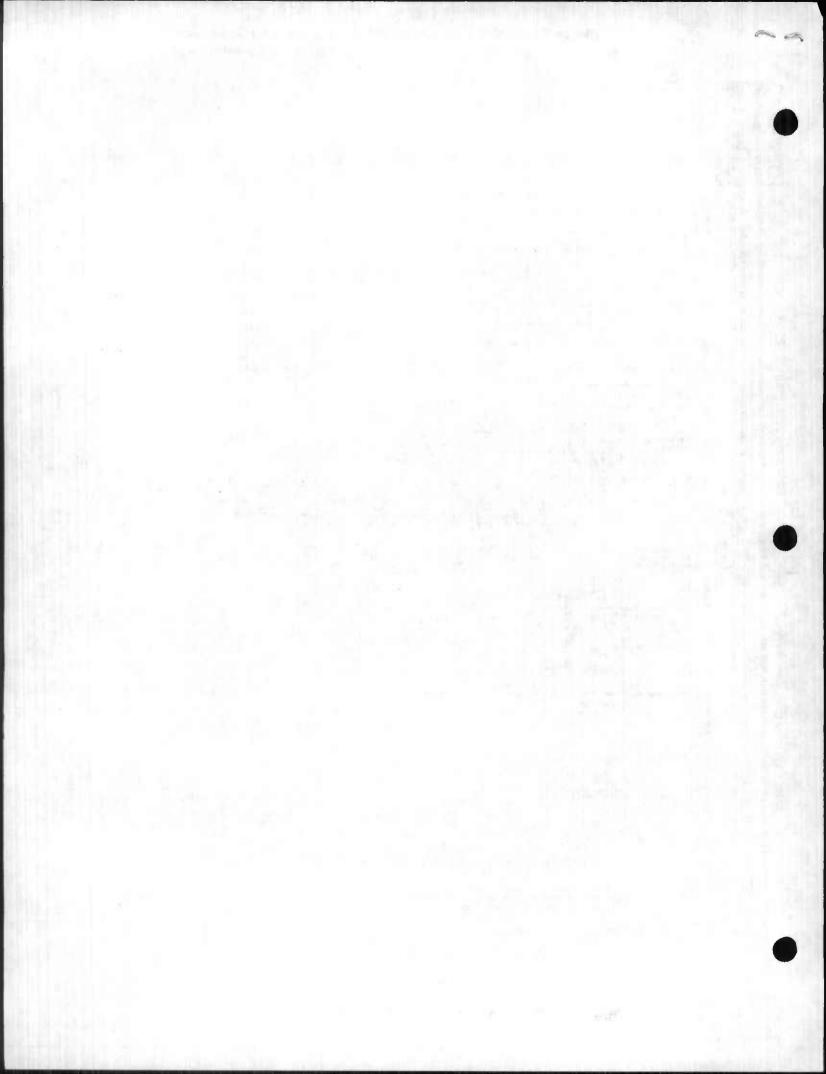
				Cer	tificate c	of Death	7	Re	g. No.		
Physicia	TIPIN	la, Last)	FI DA		BROOM	E		2. Data of Deat Month AUGUST	h Day	Yaar	3. Time of Death 04:01 am
/Medic Examin	do Foothis Manny /// and Innelled	AND THE RESERVE OF THE PERSON NAMED IN				4b. City, To		cation of Death	4c. County		04:01 am
Funeral Director	5. Social Security Number 212–24–4428		. Aga (In yrs. last	birthday) Yrs.	If Undar 1 Ye Months Da		r 24 Hrs. Min.	8. Data of Birth (Month, Day, Oct. 14	Year) 1926		ace (State or Foreign ry) yland
syland flat	Usual Rasidence of Decedant 10a. Stata 10b. County		10c. City, To					OCL. 14	, 1920		d. Inside City Limits
or 25s-f	10e. Street and Number	lvert		Owi:	10f. Zip Cod			10	Og. Citizan of V		1 ☐ Yas ŽÍŽÍNo
at Silver	2322 Fifth				207				USA		
020 ours after de set, or Hern Examiner,	11. Marital Status 1 Never Merried 2 Mer 3 Widowed 4 Divorced	ried 1 Yas 2	No No		Vas Decedent of Yas, specify C			ecify Yas or No- Rican, etc.)	Blac	- America k, White, e	tc.
21215-0020 d within 72 hours at piens. or then "netural", or the Medical Exam	15. Decedar (Specify only higher	nt's Education est grade completed)	16	(Giva)	ant's Usual Oc kind of work do NOT use re	na during mo	st of work	ing	16b. Kind of Bu	sinass/Ind	ustry
212 d willing gienne r than	15. Decedar (Specify only higher Elementary/Secondary (0-12)	College (1-	(or 5+)		omestic				Chur	ch	
Du the the deliber	17. Father's Name (First, Middle,							a (First, Middle, A		_{a)} homas	
Maryland 62 should be fin th and Mental Hy 7 is marked othe treumatic event	P Thomas 19a. Informant's Name/Relations		Chase	9b. Mailin	n Addrass (Str		eatha bar or Run	al Routa Number			
Ma allh ar 27 is artreu	Joyce Estep/Da				Fifth S			, MD 20			
altimore mit. Pages 1 c partment of He contant: If Hem r Injury or othe	20a. Mathod of Disposition 1 ☒ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (5		cema	tary, cram	ition (Nama or latory or other Jones	place)	ery8/	- 112	chesape		each, MD
Balt permit. Departments any ink	21. Signature of Funaral Sarvice		0		Nama and Ad		26	well Fur			MD 20678
death certificate be executed the extending physician and for use as the burial-fransit and for use as the burial-fransit.	Immediata Causa (Final diseese or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last	a	Dua to (or as Dua to (or as	a consequ	uance of):	he	Pul	monas)15	eose	Onsat and Death
O. Bo	Part II. Other significant condition	one contributing to dea	th but not resulting	o in the un	idarlying causa	given In Part	11.	23b. Did to	bacco use co	ntribute to	the cause of death?
D day	luna luna	pronci	hagenic	- (ance	_		12/2	es 2 No	3 Prob	ebly 4□Unknown
Cord requir	Completed							24a. Was a perform	n autopsy nad?	con	ra autopsy findings ilable prior to apletion of cause leath?
- F # 6	Co							1 🗆 Ya	as 20 No	1□	Yes 20 No
Of Vital Physician: The this certificate ral director, pag	25. Was casa rafarred to medica axaminar?	Hospital:	- V		-5-0	Other:		h (Check only on			
Phy Phy	F	28a. Data of		Outpatient Time of Injury	28c. I	njury at Work? 1 ☐ Yas 2 ☐		oma 5 Resida 28d. Dascribe ho			9
DIVISION To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	27. Mannar of Death 1 Natural 2 Accident invast 3 Suicide 6 Could 4 Homlcida detarr	not be 28a. Place o	of Injury - At homa, g, atc. (Specify)	farm, stre				28f. Location (St City or Town		er or Rura	Routa Number,
DIVI To the Heapital or At within 24 hours after To the Funeral Direct completely filled in by	29a. Certifier Certifyle	ng Physician: To the b Exeminer: On the bas end manne	is of axamination								
To the To the comp	29b. Signatura and sittle of contille	W			29c Lic	ensa number	49	2	9d. Data signe	d (Month, L	Day, Year)
6	30. Nama and addrass of person DR.DAVID GAI			RINC		DERIC	K, M	ID 2067	8		
Sta	31. Data filed (Month, Day, Year	32. Re	gistrar's Signatura		4	-	4				

And the second of the second

State of Maryland / Department of Health and Mental Hygiene

Dissolution	Amended item #17 1. Decedent's Name (First, Middle, I	.ast)		illicate of	Death	2. Date of Dea			399 ime of Deeth
Physician /Medical	Kaipi	David Cub	oitt			August			:19 AM
Examiner	4a Facility Neme (If not Institution, g Frederick Men		:a1		4b. City, Town, or Frederi	ck	4c. County Frede		
Funeral Director	5. Sociel Security Number 220–05–8092 Usual Residence of Decedent	Sex 15√M 2□ F 7. Age (I	n yrs. last birthday) Yrs.	If Under 1 Yeer Months Deys			, 1912	9. Birthplace (S Country) Mary La	state or Foreig
death with the Maryland mms 23a or 28a-f ahow if must be notified meral Director	10a. Stete 10b. County		oc. City, Town or Lo Frederick						ide City Limit XYes 2□N
iter death with the Ma r Hema 23a or 28a-f a near must be noutled Funeral Director	10e. Street end Number 22 Frederick	Avenue		10f. Zip Code	21701		10g. Citizen of V	What Country?	
ar. or he by Fu	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 20 No If Yes, Give Year or Detes:		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☐ No	Hispenic Origin? (Spen, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		e - Americen Ind k, White, etc. White	en,
c - 3	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	rking		isiness/Industry	ny
T T T T T T T T T T T T T T T T T T T	17. Fether's Neme (First, Middle, Las	James O. Ci	ubitt		18. Mother's Nei	me (First, Middle,		awley	
A SE SE	19e. Informent's Name/Reletionship Mrs. Helen G. Cu		19b. Mailii 22 F	ng Address (Street rederick	Avenue,	Frederic	or, City or Town, ck, Mary	Stete, Zip Code, 71and 21	701
permit. Pages 1 and Depertment of Health Important: If item 27 eny injury or other ti pages.	20a. Method of Disposition 1 ② Burial 2 Cremetion 3 4 Donetion 5 Other (Spec	Removel from State	20b. Place of Dispo cemetery, crea Mount Oliv	metory or other ple	y, Aug. 5,	Dete 2000		City or Town, St	
Depertment Depertment Important: I eny injury o	21 Signeture of Funeral Service Lin	basford MOO	021	Neme end Addr Keeney a 106 East	ess of Facility nd Basfor Church	d PA Fu	neral Ho derick,	me Md. 217	01
hysician	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications thet caused the yone cause on each line.	e death. Do not en	ter the mode of dy	ing, such as cerdia	or respiratory er	rest,	tnten	eximate at Between t and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	estive He		ure			1 y	rear
n and iel-transit			e to (or as a consecution of the		hy			У	ears
			e to (or es a consec ic Stenos					2	ears
9 6	thet initieted events resulting in death) Last	Due	e to (or es e consec	uence of):					
the atter hed for u	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying ceuse g	iven in Pert I.	23b. Did t	obacco use co	ntribute to the c	auee of deat
requires that the death cer been signed by the attendir should be detached for use leted by Physician/I	Colon Can	cer Stage 2B		9. 7		10	Yee 2□ No	3 Probably	4X Unkno
the law requires tate has been sign, page 2 should be Completed by					1071		en autopsy med?	24b. Were au available completi of death?	prior to
s certificate has director, page 2					26 Pleas of De	1□ \ eth (Check only o		1 🗆 Yes	2 No
	examiner? 1 ☐ Yes 2]Q No	Hospital:	2 ER/Outpatie	nt XIX DOA	thor:	fome 5□ Resid		er (Specify)	
After Fund			aar) 28b. Time o	W	ury et ork?] Yes 2 No	28d. Describe h	now injury occur	red	
ris effection: **A Director: After led in by the funeral Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury building, etc. (.		reet, fectory, office		28f. Location (5 City or Tox	Street and Numb vn, Stete)	per or Rural Rout	e Number,
in 24 hou he Funer pletely fii	29a. Certifier 1 Certifying F (Check only 2 Medical Exc	Physician: To the best of mariner: On the basis of ex and menner states	amination and/or in						ause(s)
Toth		/			32245		29d. Date signe August	d (Month, Day,) 4, 2000	'ear)
	30. Name and eddress of person who Amy Jones				ive, Fred	erick. M	laryland	21702	
State	31. Dete filed (Month, Day, Year)	32. Registrer's		6					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

26400 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** 6:10 PM Robert Fleming Christensen, Sr. 8 3 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 3 East 15th Street Frederick
If Under 24 Hrs. Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yea 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours 15M 20 F Months Deys Director 573-24-1498 73 Dec 29, 1926 California Usual Residence of Deceden 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Exemples must be notified at 1 Ves 2 □ No Director Maryland Frederick Frederick the 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 3 East 15th Street 21701 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 SYes 2 No 1954 If Yes, Give Year or Detes: -1974 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced -1974nd 2 should be filed within 72 hour alth and Mental Hygiene. 27 Is marked other than "natural or traumatic avent, the Medical E. Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 career military US ARMY permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other any injury or other traumatic avant, page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Christensen Margaret Fleming 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Okhi Christensen / wife 3 East 15th Street, Frederick, MD 21701 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Olivet Cemetery 8/8/00 Frederick, Maryland 22. Name end Address of Facility
Stauffer Funeral Homes, P.A. 21 Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pert1. Enter the disease, or complications that caused ter death. Dishock, or heef fellure. List only one cause on each line. not enter the mode of dying, such as cardiec or respiratory errest, Approximete friterval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In death) m myelo Senou
Due to (or as a consequence of): Examiner Examiner physician and the buriel-transit Sequentielly list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical Due to (or es a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PO 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s 1□ Yes 2 No 1 Yes 2 No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 20 No 2 this 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural Division or Attending 5 Pending investigation n 24 hours after death.

Per Funeral Director: After oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide Hospital 29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piace, and due to the cause(s) end manner as stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 48184 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Frederick MD 21701 Elhamy Eskander MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State 2000 Registrar

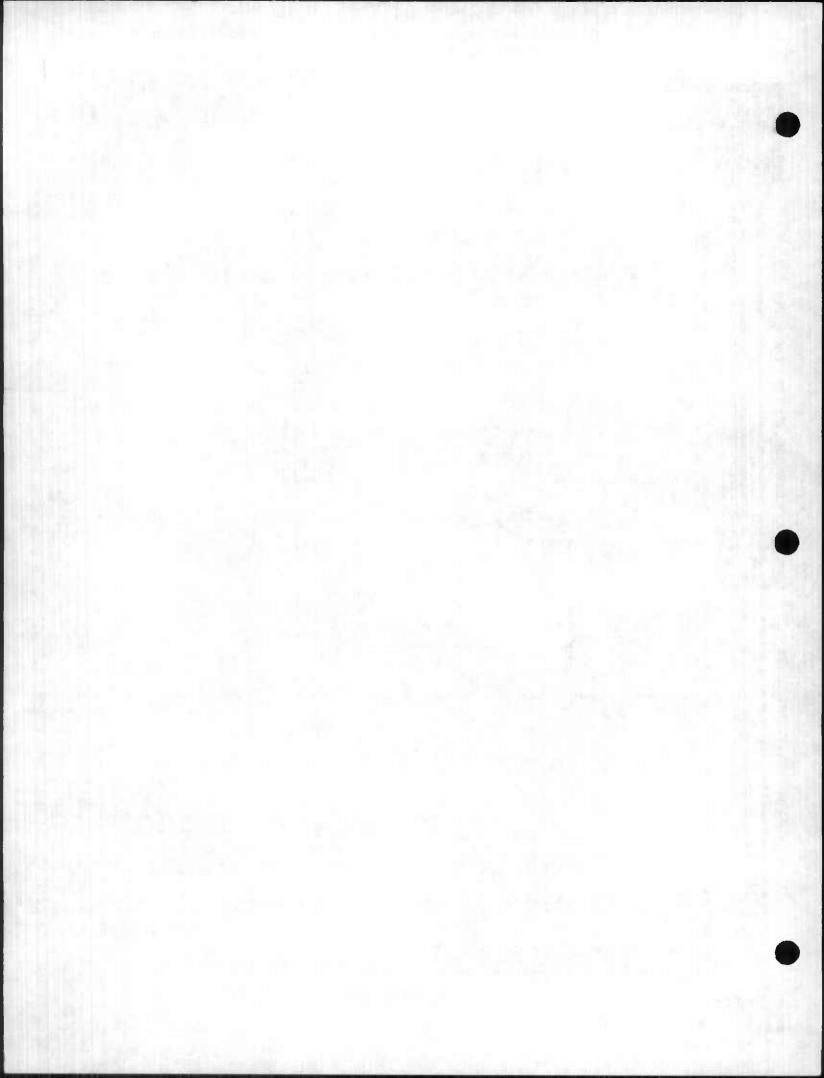
DHMH 16 Rev 6/95

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State of Manyland / Department of Health and Mental Hygiene

amend item	26 per phys. G786 8/24/	State of Maryland 00 yf	/ Department of Certificate			jiene leg. No. 0 (26401
Dhysisian	1. Decedant's Nama (First, Middle, Last	")			2. Date of Dea Month		3. Time of Death
Physician /Medical	Mary Ethel Cha	pman			August		
Examiner	4a Facility Name (If not institution, giva	street end number)		4b. City, Town, or Lo		4c. County of	
THE PLANT	14650 Poplar H	ill Road		WAldo			rles
Funeral Director	5. Social Security Number 6. Se 579-24-2325	7. Age (In yrs. la:	st birthdey) If Under 1 Months C	avs Hours Min.	8. Date of Birth (Month, Dey anuary	Year)	9. Birthplace (State or Foreign Country) 16 Marylan d
2 .	Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Location				10d Inside Oits I imite
athon athon							10d. Inside City Limits 1 ☑Yes 2 ☐ No
or 28e-f-s or 28e-f-s os notifies Directo	Maryland Charle	es v	Valdorf	wda.		Og. Citizen of Wh	
						og. Onizen or vivi	at Courty?
na 23	14650 Poplar Hi	. LL Rd 12. Was Decedent Evar in U,S.		601 t of Hispanic Origin? (Spe	cify Yes or No-	U.S.A	- American Indian,
Maryland 21215-0020 d 2 should be filed within 72 hours after death of a should be filed within 72 hours after death of an and Mental Hygiest "natural", or items 23 traumstic event, bit Medical Examines must traumstic event, bit Medical Examines must To Be Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yas, specify	t of Hispanic Origin? (Spe Cuban, Maxicen, Puarto Mo Specify:	Rican, etc.)	Black,	White, etc. Black
O of 2 to bet	15. Decedent's Edu		16a. Decedent's Usual (Occupation	0.0	16b. Kind of Busi	
1 21215-0 ed within 72 ho yglene. er then 'netur r, the Medical Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		fone during most of working tired)	ng		
N Maria	12		Seamtre	SS		Self-E	mployed
De de de de de de de de de de de de de de	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Sumema)	
ylar Menta M	John Cha	pman		Irma		Yates	
and and and and and and and and and and	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailing Address (S	treet and Number or Rura			
ET TO 896 Av.	Delores Brooks		50 Poplar				land 20601
altimore, mil. Pages 1 a partment of Hea portent: If them 3 y injury or other 26.	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	000	ce of Disposition (Neme netery, crematory or othe	of or place)	Date	20c. Location - C	ity or Town, State
Pag Pag uny our	4 Donation, 5 Other (Specify)	St.	Peters Ce	m. August	12,200	00 Wald	orf MD
Balt permit. Depart import any inj	21. Signature of Foreral Service Licens	M191		Address of Facility	- D 3		20608 co MD
	23a Part Enter the disease, or comp			uneral Hon dying, such as cerdiac of	or respiratory ar	est,	Approximate
Physician	shock or heart failure. List only o	ne ceuse on each line.					Interval Between Onset and Death
/Medical	Immediate Cause (Final	Leukemia					1
Examiner	disease or condition resulting in death)	a	as a consequence of):				
je literatura je		Due 10 (01 1	as a consequence ory.				
8760, ate be executed hysician and the burial-transit	Sequentially list conditions, if any, laading to immadiata	b Due to (or a	as a consequence of):				
a price & OF	if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events	C			10-11-1		
0 0 0	resulting in death) Last	Dua to (or a	is a consequence of):				
XX Certi		d					
Box eath cert attendin for usa	D 44 04 4 4 4			or the last to make a s	1 con plan		There as the server of death 2
S, P.O. Box as that the death certi goed by the attending be detached for use a by Physician/M	Part II. Other significant conditions con	ntributing to death but not result	ing in the underlying ceu	se given in Part I.			ributs to the cause of death?
dS, P signed b d be dete					101	SS ZUNO	3 Probably 4 Unknown
Cord					24a. Was a perfor	an autopsy med?	24b. Wera autopsy findings available prior to completion of ceuse of death?
The law ate has to page 2 s					10	00 327 WO	1 ☐ Yes 2 ☐ No
Vital This certificate rector, pag	25. Was cesa referred to medical			26. Place of Death		es XXXX	10165 2010
Of Vita Physician: this certific ral director.	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA	Other		ence 6 Other	(Specify)
Physic rithis constitution of 1	27. Manner of Death					ow injury occurre	
On Oil	XXXatural 5 Panding Invastigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division or Attending after death. Director: After d in by the fune ertification	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, street, factory, o	ffice			r or Rurel Routa Number,
Division C be or Attending P is after death. at Director: After t led in by the funera Certification:	4 Homicide	building, etc. (Specify)			City or Tow	n, State)	
Division within the Hospital or Attention within 24 hours after deat completely filled in by the Medical Certifical	29a. Certifier XX Xertifying Phy	sician: To the best of my knowl	edge, death occurred at	the time, date and place.	and due to the d	ause(s) and man	ner as stated.
n 24 hound n 24 hound	(Check only 2 Medicat Exami	ner: On the besis of examination and manner stated.	on and/or investigation, in	my opinion, death occurr	ed at the time, o	date and place, sr	nd due to the cause(s)
To the vithin 2 To the comple	29b. Signature and title of certifier		29c. l	icense number		29d. Date signed	(Month, Day, Year)
- > - 0	1 well	M. M.H	100	D28352		Augus	t 7, 2000
	30. Name and addrass of person who co	omplated ceusa of death (ttem 2	23a) (Type, Print)				
	Krishan Mathur	· ·		La Plata	MD 2	20646	
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signatu	re	4			
Registrar	AUG 0 8	2000 Dener	w 19. 1	park)			

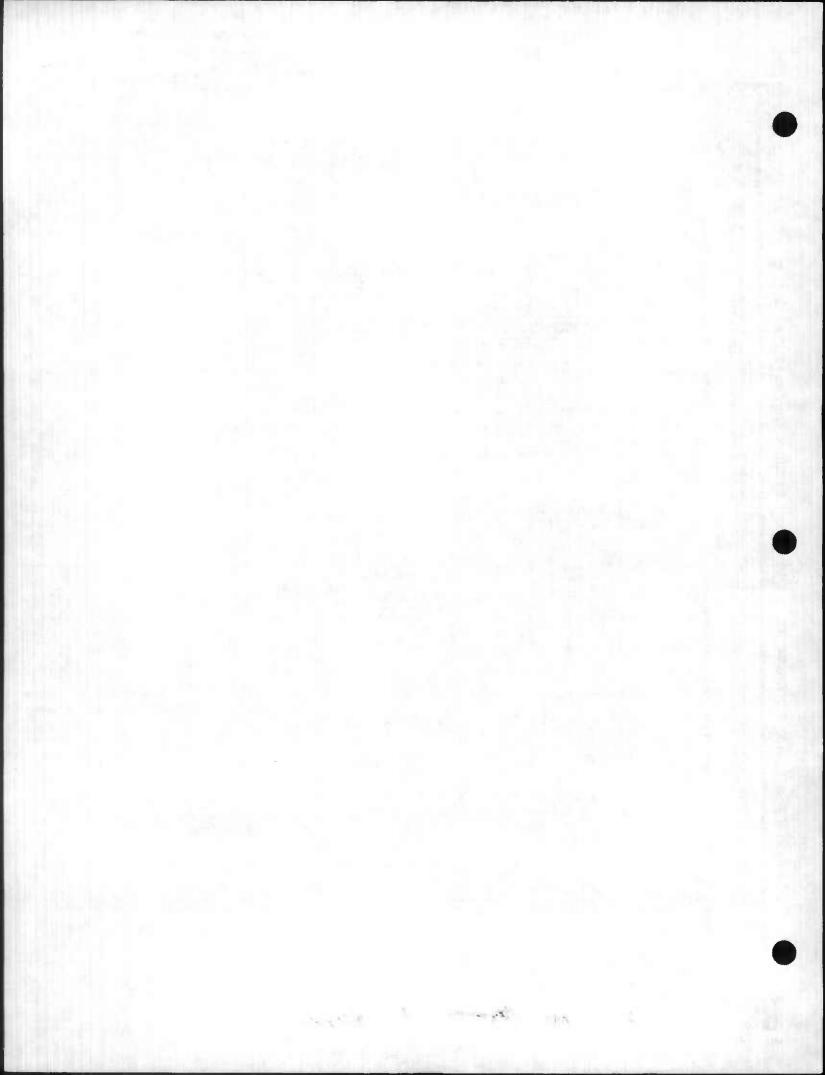
DHMH 16 Ray 6/95



	Decedent's Name (First, Middle, La	st)		Certificate of	Death	2. Date of De			3. Time of Death
cian dical		Lewis Dan					2, 2000	Year	8:20 PM
niner	4e Facility Name (If not institution, given 201 Car	re street and numbe toctin Av			4b. City, Town, or Freder			of Death reder	ri ola
al or	5. Social Security Number 220-05-7975 6. S		Age (fn yrs. last bi	Yrs. If Under 1 Ye	er If Under 24 Hrs	8 Date of Birt			ace (State or Foreign ry)
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	m or Location				10	d. Inside City Limits
ō		erick		derick					Yes 2 No
Funeral Director	10e. Street and Number	DL LCIK	110	10f. Zip Cod	θ		10g. Citizen of W	hat Count	ry?
	201 Cato	ctin Ave.		21	701	100	U.S.A		S May In
	11. Maritel Status 1 Never Married 2 Married	If Yes, Give	NoW. W.	13. Was Decedent If Yes, specify C	of Hispenic Origin? (Stuban, Mexican, Puerl	specify Yes or No to Rican, etc.)		- America , White, e	tc.
l	3 Widowed 4 Divorced	Yeer or Dates			Marian III				
	15. Decedent's Elementery/Secondary (0-12)	College (1-40)	168 r 5+)	Decedent's Usual Oc (Give kind of work do life. DO NOT use re Mechanic	cupation ne during most of wo lired)	rking	16b. Kind of Bus		ustry
1	17. Father's Name (First, Middle, Last,)			18. Mother's Ner	me (First, Middle,	Maiden Sumame		
	Harvey L	. Danner			Lucy	Nash			
	19a. Informant's Name/Relationship (190	o. Mailing Address (Str				State, Zip	Code)
	Mary I. Danner (Wife)	last a		tin Ave.,			2170	
	20a. Method of Disposition 1 X Burial ♣ ☐ Cremation 3 ☐	Removel from Stat	camete	of Disposition (Name of ry, crematory or other	placa)	Date O / 5	20c. Location - (
	4 Donetion 5 Other (Specif	-	rieas	ant View C	1		Burkitt	SVIII	e, MD.
	21. Signature of funeral Service Liber	horse		31 E. Ma	dress of Fecility • Thompson in St., Mi	ddletown	1, MD.	21769	
	23a. Part T. Enter the disease, or comshock, or heert feilure. List only	plications that ceus one cause on each	ed the deeth. Do line.	not enter the mode of	dying, such as cerdia	c or respiratory a	rrest,		Approximate Interval Between Onset and Deeth
	Immediate Causa (Final disease or condition resulting in death)	e. cong	estive t	eart fa consequence of: heart	ilure			† † = 0	weeks
Examiner		1100	Due to (or as a	consequence of):	disease			1	years
	Sequentially list conditions.	b. Val		consequence of):	OIT-0-C				years
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events								
	that initiated events resulting in death) Lest	C.	Due to (or as a	consequence of):	Hell Mills				
/We		d							
3	D 40 O4 1 10 10 10 10					ant miles			Ab (dAb (
Wanning for the parameter of	Part II. Other eignificant conditions of Chronic obs 4								the cause of death?
2000	Chronic obst dementia	Park	nsons	disease			an autopsy rmed?	con	re autopsy findings ilable prior to apletion of cause leath?
5						10	Yes 20 No	1 🗆	Yes 2□No
Be	25. Was case referred to medical examiner?					ath (Check only o	one)		
2	1 Yes 2 No		tient 2 ER/O			-	dence 8 Othe)
o	27. Manner of Death 1 ☑ Neturel 5 ☐ Pending	28a. Date of In (Month, D	jury lay Year) 28b.		njury at Work?	28d. Dascribe	how injury occurre	ed	
cat	2 Accident investigation 3 Suicide 6 Could not b	e on place of l	nium. At home f		I □ Yes 2 □ No	28f Location /	Street and Numbe	or Or Rura	Route Number
=	4 ☐ Homicide determined	building,	etc. (Specify)	arm, street, factory, off	ce	City or To		or un riunes	rioute Number,
edical Certification:			of examination ar	e, death occurred at the					
M	29b. Signature and title of certifier	Ond monnor	nato.	29c. Lic	ense number		29d. Date signed	(Month, I	Day, Year)
	Valle.	.) 810	411	D.	77077		8/8/0	7	
- 1	FINALULA /	NOHM	1	D.	22013		01010		
	30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)					
	30. Name and address of person who Kathleen W. St	completed ceuse of	death (Item 23a)	(Type, Print) Ninth A)	re Brun	airck	Md. 21	716	

DHMH 16 Rev 6/95

ORIGINAL



				Certifica	ate of	Death		Reg. No.			
	1. Decedent's Name (First, Middle, Last))					2. Date of Dec	oth Day	Year	3. Time of	Death
sician edical _		EMMA LOUIS	E ELI	ZABETH	DAVI	S	August	,	000	1630	
	4a Facility Neme (ff not institution, give :	street and number)	- 10			4b. City, Town, or	Location of Death	4c. County	of Death		
	Genesis Spa Creek	Center				Annapol	is	Anne	Aruno	de1	
	5. Social Security Number 6. Sec	7. Age (In y	rs. last birt	hday) If Und Month	der 1 Year	If Under 24 Hr		h v. Year)	9. Birthple	ace (State o	or Foreig
	215-17-1077	JW 51971- {	30	rs.			May 10		Mary:		
	Usual Residence of Decedent 10a. State 10b. County	100	City Town	or Location					140	od. Inside C	lane t Lumia
4	Toa. State	100.	City, Town	or Location					10	1 Yes	
	Maryland Anne Ar	undel /	nnap								2014
5	10e. Street and Number				Zip Code			10g. Citizen of V	What Count	ry?	
	35 Milkshake Lane				21401				S.A.		
	11. Meritei Stetus	12. Wes Decedent Ever in Armed Forces?	U,S.	13. Was Dec	cedent of F pecify Cubi	lispenic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rac Blac	ce - America ck, White, e		
	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:				Specify:		Specify		ite	
-	15. Decedent's Edu	cation	16a.	Decedent's U	aual Occup	ation		16b. Kind of B			4, 5
name di man	(Specify only highest grade	e completed)		(Give kind of life. DO NOT	work done use retire	during most of wo	orking				
	Elementery/Secondery (0-12)	College (1-4or 5+)		Homema				Own	n Home	e	
	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle,				
o ge	John A. Brashears					Georgi	a Zula L	owe			
	19a. Informent's Neme/Reletionship (Ty	me Print)	19h	Meiling Addre	ess (Street		Rural Route Numbe		State Zin	Code)	
	Judith A. Weitzel			-			Severna				
1	20a. Method of Disposition		p. Piece of	Disposition (A	Vame of		Dete	20c. Location -			
	1 ☐ Burial 2X Cremation 3 ☐ R	temovel from State		y, crematory o burg Ci			8/10/00				and
-	4 Donetion 5 Other (Specify) 21. Signetus of Fundal Selection		ILLIA			ss of Facility	5/10/00	DILLCHSD	urg, r	lal y La	and
	Immediate Cause (Final disease or condition resulting in death)			Lemi		adio	my opal	Щ		Onset end	1)
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or es e c	onsequence o	of):				1		44
edicar	Cause (Disease or Injury that initiated events resulting in death) Last	Due to	(or es e c	onsequence o	of):						
20		1							1		
E L									1		
Physician/A	Pert II. Other eignificant conditions con	tributing to death but not	resulting in	the underlying	g cause giv	en in Part f.		obacco uee co			
							10	Yee 2 No	3 Prob	ably	Unkno
orden by								an autopsy med?	con	re autopsy Illable prior Impletion of o	to
							32		of d	death?	
Completed				5-101		THE PERSON	101	les 2 No	1 🗆	Yes 2] No
ן מ	25. Was case referred to medical examiner?				-		eath (Check only o	ne)			
0	1 Yes 2 No		□ ER/Out	tpatient 3	DOA Oth	ner: Nursing	Home 5 Resid	dence 6 Oth	ner (Specity)	
	27. Manner of Death 1 Anatural 5 Pending	28a. Date of Injury (Month, Day Year	28b. T	ime of	28c. Inju	y at rk?	28d. Describe I	now injury occur	rred		
Cel micanon.	2 Accident investigetion 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, fer	m, street, fact		Yes 2 No	28f. Location (S City or Tov	Street and Numb m, State)	ber or Rural	l Route Nun	n <i>ber</i> ,
	(Check only 2 Medical Examir	sician: To the best of my liner: On the basis of exam									s)
1000	one)	end manner stated.						and Data data	- d /0.4	Day Marak	
	29b. Signeture and title of certifin	Com			29c. Licens	320.	36	29d. Date signe	200	Day, Year)	
-	30. Name and address of parces	III ploted cause of deeth (I	tom 22a) (Time Print)	}	,		-/-	- 4		
	30. Name and address of person with the control of	pleted cause of deeth (I	108	P. De	rabo	Drun	36 Chsi	ler, M	0 2	1619)
te	31. Dete filed (Month, DAUG) 1	2000 32. Registra is Sign	neture	, 4		1				No.	

State of Maryland / Department of Health and Mental Hygiene 26404 amend item 5,18, per fh G786 8/21/00 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** EARIE HELENA J UNE DANIELS 2000 9:50 PM /Medical 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DENTON CAROLINE SHORE NURSING & REHABILITATION CTR. 7. Age (In yrs. last birthday) If Under 1 Yeer Months Days If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 206-12-4073 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Hours Maryland 407 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow mant be notified at Yes 2 No PA Delaware Director Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 737 Engle St. 19013 USA items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Status Black, White, etc. traumatic event, the Madical Examiner 72 hours after 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify: by Black 3 X Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) OWN Home tomemaker Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be finent of Health end Mental Hant: If Item 27 le marked of Daisey Wright-Lake Daisey Wright-Lake Daniel Lake 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9157 Tuckahoe Rd. Denton, MD 21629 Jackie Thomas other Saltimore, 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 Department of Important: If any Injury or 6/26/00 Spring Grove Denton, MD 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Harvey C. Smith, Jr. 1000 N DuPont Pkwy, New Castle, DE 19720 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting In death) /Medical 6mo. Examiner by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Due to (or es a consequence of) P.O. Pert fl. Other aignificant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 220 3 Probably 4 Unknown of Vital Records, heumatoid arthritis 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed After this certificate has 1 Yes 2 200 1 Yes 2 No al or Attending Physician: T s after death. It Director: After this certificat ed in by the funeral director, p 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 1 Yes 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Watural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital o within 24 hours af To the Funerel DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier completely 290. Signature and this of contribut 29d. Date signed (Month, Dey, Year) 29c. License number D35284

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 6 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

5.

washington St Easton mo 21601

MOUTH COLDENS

ALCOHOL: ORGANIE

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					C	ertificate of	Death		Reg. No	o. U U	20	7400
Physici	an	1. Decadant's Nama (First, Mic		la Irene	Fret	7		Monti		эу .	Yaar	3. Time of Death
/Medic					1166			Augus				1:00 A.M.
Examin	er	4a. Fecility Neme (If not institute Mennonite Fe					Hagers	town		. County o lashir		
Survey.		5. Social Sacurity Numbar	6. Sax	7. Aga (In yrs.	. last birthda	(av) If Under 1 Yaar					9	ca (Stata or Foraign
Funeral Director		220-46-8216 Usuei Residence of Dacadent	1□M 20XI			Months Days	Hours	Min. (Mont	of Birth h, Day, Year 12,191	2	Mary	/)
yland		10a. Stete 10b. Cour	ity	10c. C	ity, Town or	Location					10d	I. fnside City Limits
e Mai	ctor	Md. Was	shington		Hage	rstown						1 □ Yas 2 No
Aaryland 21215-0020 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is and Mental Hygiene. Is marked other than "naturel", or frems 23s or 28s-f show reurnetic event, the Medical Examiner must be not fed at	ai Director	10a. Street and Number 12349 Huyett	Lane			10f. Zip Coda 2	1740		-	itizen of WI		n
dea dea	Funerai	11. Meritei Stetus	12. Wes D	ecedent Ever in U Forces?	J,S. 1	3. Was Dacedant of if Yas, specify Cul	Hispenic Origi	n? (Specify Yas	or No-		- American . Whita, ato	
0020 ours afte	by	1 ☐ Navar Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce	arried 1 ☐ Ya If Yas,	as 2 No Giva or Datas:		1□Yas 2XNo				Specify:	Whit	
72 h	etec	15. Daced (Specify only high	ant's Education hast grada complate	ed)	16a. De (G	cedant's Usuai Occu iva kind of work done a. DO NOT usa retin	upetion a during most o	of working	16b. F	(ind of Bus	inass/Indu	atry
121 within	Completed	Eiamantary/Secondery (0-12) Collag	a (1-4or 5+)	life		ed)		1J	lo a 1 + h	Came	
d 2 High	Co	12 17. Fether's Nema (First, Middle	a. Last)	5+		Nurse	18. Mother	s Nama (First, M		lealth		3
d be ental	To Be			Eshleman				nda Wea		, comouno	,	
Marylic d2 should d2 should h and Mer 7 is merke traumetic	F	19a, Informant's Name/Raiatio				ailing Addrass (Stree	at and Number	or Rural Routa N	lumber, City	or Town, S	itete, Zip C	ode)
Mand 2 aith a 27 is 27 is pr tra		Lois Keener/	Daughter			859 Cearf						
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours aft Department of Health and Mental Hygiene. Important: if item 27 is merited other than "natural", or any injury or other traumetic event, the Madical Examples.		20e. Mathod of Disposition 1 X Burial 2 ☐ Cramatio 4 ☐ Donation 5 ☐ Other			cematary, c	sposition (Nama of tramatory or other plans nonite Church	ch Cemet	ery 817		ocation - C		
Balti Permit Depenit Important Important any Injury		21. Signature of Funarai Service		7		22. Nama end Addr Zimmerma	ress of Fecility	, ,				
2		H. Marline	Mmen-			45 S. Ca	rlisle	St. Gre	encast		a. 17	7225
		23a. Part1. Enter the disease, shock, or heart failure. L	or complications the ist only ona causa o	at caused tha dae on aach lina.	th. Do not a	antar tha moda of dy	ring, such as ca	ardiec or respiret	ory errest,		tr	pproximete nterval Between Onsat and Death
Physician /Medical		tmmadlata Causa (Final		C. 05-		. 11.	. ^					~ Q
Examiner		disaasa or condition rasulting in daath)	a			- VLE	213				1	dure
1	ner		1	2000/1	or as a cons	sequance of):	SALC	ATTO.	115		1	
Cuted cuted fransi	Examine	Sequentially fist conditions,	b	Dua to (or as a cons	sequence of):	CRIC	-1100				
So as as working a supply of the supply of t		Sequentially fist conditions, if any, taading to Immadiata causa. Entar Undarlying Causa (Disaasa or injury	J .								i	
Is, Po. Box 68760, es that the death certificate be axecuted igned by the attending physician and be detached for use as the burial-transit	Medicai	that initiated evants resulting In death) Last	C.	Due to (d	or as a cons	sequence of):					i	
Se ass			d									
BOO Battendi for use	by Physician										1	
the de	ysi	Pert II. Other significant condi			^	, , ,	ivan in Part I.	23b.		-1		he cause of death?
that the delete	y PI	N312,	OHD	, A-S	01-)			1 ☐ Yee	2 No	3 Probai	bly 4 ☐ Unknown
Division of Vital Records, P.O. Bo) or Attending Physician: The law requires that the death ce birer clear After this certificate has been signed by the attend in by the luneral director, page 2 should be detached for us.		•						24a.	Was an euto	opsy	24b. Wers	a autopsy findings able prior to
aw re 2 sh	Completed							_	portonida			plation of cause
The The page	Con								1□ Yas 3	No	101	Yas 2□ No
Vital Rec	Be	25. Was casa refarred to mediaxaminar?				Ta	4	f Death (Check	only ona)			
Of Of Physics of this of the all directions of the orange	5	1 ☐ Yas 27 No 27. Manner of Death			ER/Outpet	tient 3LI DOA			Rasidanca			
After Iuner	tion	D⊠Natural 5 □ Pane	ding (M	ita of Injury Ionth, Day Year)	28b. Time tnjur	y Wo	unyat ork? ⊒Yas 2∐No		cribe how inju	iry occurre	a	
Witen deat ctor: y the	Certification:	3 ☐ Suicida 6 ☐ Coui	d not be	ace of Injury - At h	oma, farm.	street, factory, office			tion (Street a	nd Numbe	r or Rural F	Routa Number,
Div Dire	erti	4 Homicida Gata	bu	ilding, atc. (Speci	fy)			City	or Town, Stat	a)		
Division of Vita Within 24 hours after death. To the Funeral Director: After this certification of the Funeral Director. After this certification is the funeral director, and the funeral director director, and the funeral director director, and the funeral director dir	edicai	29a. Certifiar (Check only one)	at Examiner: On the	tha best of my kno a basis of axamina annar stated.	owledga, da ation and/or	ath occurred at tha t investigation, in my	time, data and opinion, daath	piace, and dua to occurred at that	tha causa(stima, data an	s) and man od piaca, ar	nar as statend dua to the	ed. na cause(s)
o the	Me	29b. Signeture end titla of certif				29c. Licen	nse number		29d, Dr	ate signed	(Month, De	y, Year)
		Maure	Unun	16).		D2:	3015		9	131	20	
		30. Nama and address of person	on who completed ca	ausa of daath (itae	m 23a) (Tvn		1012		9	7	00	
			2.72 4							35		
Sta	te	31. Date filed (Moeth Oay, Yes	2000 32	. Registrar's Sign	ature 4	1	1,					
Registra	ar	nou () 4	2000	A	D	Space	2					

00-4506-510 Ja JV

and Type or Drint in Plack Indellible ink Accure All Copies Are Legible

Physician /Medical		James 1	e (First, Middle, L Alan GU	INN							Date of Dea Month AUGUS	г 12.20	Year 00 0	Tima of Death 3:09 A.M.
Examiner	4a			Ve street and number HOSPITAL					BALT	[IMORI	ition of Death E		/A	
Funeral Director		ocial Security N 17 70 84		Sex 7	. Age (In yrs. la 44	est birthday Yrs.	Months	1 Year Days	H Under a	h Aire	Date of Birth (Month, Day ar • 25	, Yes 1956	9. Birthplace Country)	(State or Foreign
d show fied at	1	ual Residenca of State MD	Decedent 10b. County			Town or L Balti								nside City Limits
a or 28a-f a	106	Streel and Nur		eights Av	/e.		101. Zip	Code	6			10g. Citizen of V USA	What Country?	
monitor of the state of the sta	-	Marital Status	ied 2 Married	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	lent Ever in U,S es? M No	5. 13.	Was Deced If Yes, spec		lispanic Origin, Mexican	gin? (Speci , Puerto Ri	ify Yes or No- can, etc.)		a - American Inck, White, etc.	dian,
ygiene. Not then "natural", t, the Wedes Engle. Completed by	E	(Spec	15. Decedent's E city only highest grandary (0-12)	Education rade completed)	4or 5+)	(Give	e kind of wor	k done d e retired	during most d)	- 14			usiness/industr	
d other event, u	17.		(First, Middle, Las			seli	emplo	yea	18. Mothe		ne (First, Middle, Maiden Surname)			
th and Menta 7 is marked traumatic a		a. Informant's Na	ame/Relationship Guinn ((Type, Print)		19b. Mail 2360	ing Address Cari	(Street Ct.	and Numbe	er or Rural i	Route Numbe	r, City or Town, D 2063		(e)
nent of Health	208			□Removai from Si	CE	metery, cre	osition (Name and tory or or or or or or or or or or or or or	her plac		ens	Date 8-16-0	20c. Location - O Dunk	City or Town,	
important: if any injury or phone	21.	21. Signature of Uneven Service Licenses 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20								20736	5			
hysician /Medical xaminer	Imi	mediate Cause ((Final	nplications that only one cause on ea			OTIC I				respiratory ar	rest,	Inte	oroximate rval Between set and Death
ě	res	ulting in death)			Due to (or	as a conse	equenca of):				ni s			
clean and buriel-transit	Cau	quentially list co ny, leading to in use. Enter Unde	erlying	D	Due to (or	as a conse	equence of):							fly ly
9 0 0	tha	use (Disease or t initiated events sulting in death) I		c	Due to (or	as a conse	equenca of):							
for for	Par	t if. Other signif	ficant conditions	contributing to dea	th but not resu	lting In the	underlying c	ause giv	ren in Part I		23b. Did t	obacco uae co	ntributs to the	cause of death?
b b	-							H				Yea 2 No	3 Probably	utopsy findings
sate has been sign pege 2 should be Completed by	-										perfo	an autopsy med?	availab	le prior to tion of cause
	25	Was case refer	red to medical		1 De Yes 2 No 1 De Yes 2 No								s 2 No	
or, pege	1 -0.	examiner?		Hospital: Other:									ner (Specify)	
director, peg		1 V Yes 2	No	1 1 10				- 1			110016			
ector. Be	27.	Manner of Deat Natural Accident		28a. Date of <i>Month</i> Found: 8-12-	Injury Day Year)	28b. Time	of 2	8c. Injur Wor 1 🗆	yat k? Yes 2 🎇		3d. Describe h	now injury occur		Tin.

25. Was case examiner?	referred	to medical	
1 X Yes	2 No		

28f. Location (Street and Number or Rural Route Number, City or Town, State 5115 BENTON HEIGHTS AVE. BALTIMORE, MD

29a. Certifier (Check only one)

Medical Certification: To

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 **Medical Examiner*: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

AUGUST 12, 2000

ennis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

te wo 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

To the Hospital o within 24 hours aft To the Funeral Di

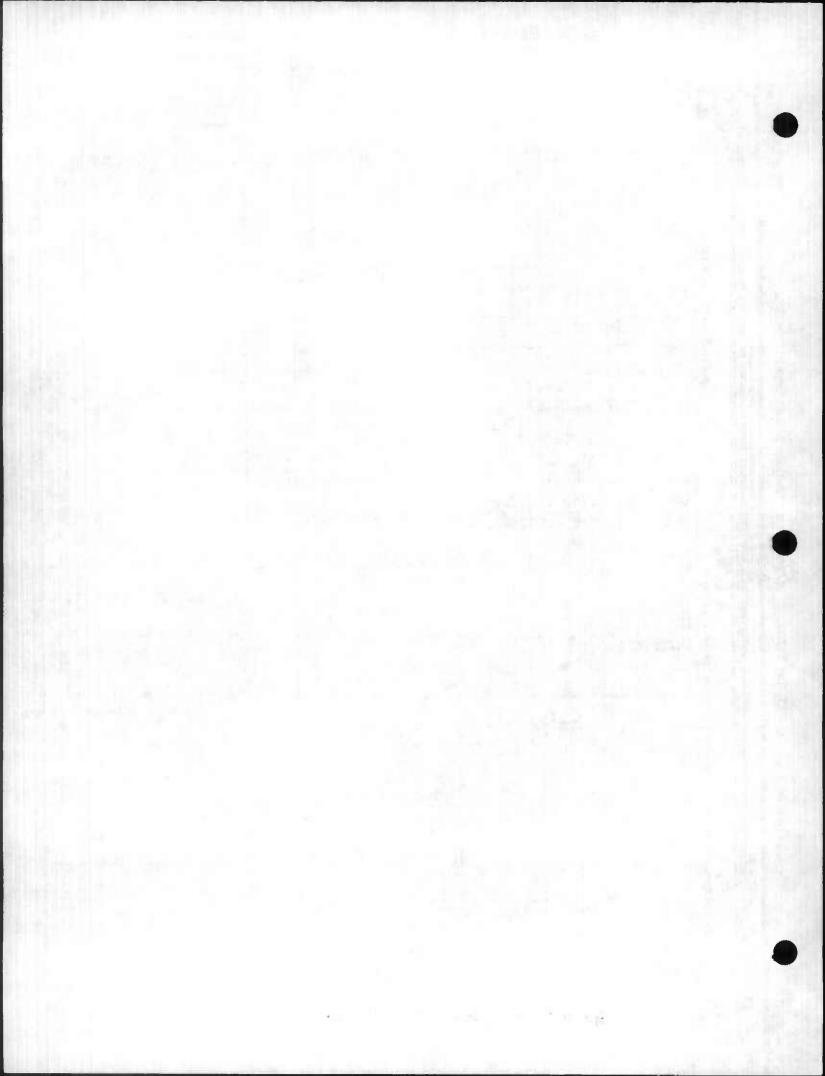
462920 from the Areas

				Certificate of	Death	Reg. No.	20401
	Physician /Medical	Decedent's Name (First, Middle, Last) Mozella		reenwood		Pate of Death Month Day Lgust I,	3. Time of Death 2000 1:50 P.M.
	Examiner	4a Facility Name (It not institution, give s St. Agnes Nursing		ation Ctr.	4b. City, Town, or Locatio Ellicott Cit		y of Death ward
	Funeral Director	370-10-3233	7. Age (In yrs. last 74	birthdey) If Under 1 Year Months Days	Hours Min (/	eate of Birth Month, Dey, Year) rch 8, 1926	9. Birthplace (State or Foreign Country) South Carolina
	Sa-f show	Usual Residence of Decedent 10a. Stete 10b. County Maryland Calvert		own or Location Dowe11			10d. fnslde City Limits 1 ☐ Yes 2 1 No
	h with the 12se or 2se	13415 Dowell Road	d	10f. Zip Code	629	10g. Citizen of US.	
020	72 hours after death with the Maryland natural", or items 23s or 28s-f show and Example in the notified in sted by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No It Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify an, Mexican, Puerto Ricar Specify:		ce - American Indien, ack, White, etc. by: Black
21215-0020	within one.	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 1- e completed) College (1-4or 5+)	6a. Decedent's Usuel Occu, (Give kind of work done life. DO NOT use retire Housewife	pation during most of working d)		Home
	B Vot H	17. Fether's Neme (First, Middle, Last) Ludie	Woody		18. Mother's Name (Fire Gertrude	st, Middle, Meiden Sumer	Beasley
Maryland	s m	19a. Informant's Neme/Relationship (Ty) Drusilla Gough/Sis		9b. Mailing Address (Stree P.O. Box 68	Dowell,		, Stete, Zip Code)
Baltimore,	Pages 1 ent of Hi nt: If iten y or oth	20a. Method of Disposition 1 🖾 Burlat 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	of Disposition (Name of elery, cremetory or other ple John UMC Cem-	000)		- City or Town, State
Balt	permit. P Departm Importan eny Injur pnce.	21. Signature of Funeral Service License	Servel O	22. Name and Addres	Dewer	1 Funeral Herince Frede	ome rick, MD 20678
x 68760,	death certificate be associed e attending physician end ed for use as the burial-transit ed for use as the burial-transit sician/Medical Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	Corein Ses cardiac or res	orma Grant	Approximate fintervel Between Onset end Death
Vital Records, P.O. Bo	aw requires that the is been signed by the 2 should be detached pletted by Physical	Part II. Other significant conditions con	stributing to death but not resulting	g in the underlying cause gi	jolly	23b. Dfd tobacco use co	ontributs to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
ital R	certificate he rector, page	25. Was case referred to medical			26, Place of Death (Ch	1□ Yes 2 No eck only one)	1□Yes 2XNo
Division of V	fer this ineral di on: To	27 Apper of Death Shatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Total Control of the	D. Time of Linjury M 1E	her: 4 Nursing Home by at 28d. 1Yes 2 No 28t. 1	5 Residence 6 □0ti Describe how injury occu coation (Street and Num	
Div	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fr Medical Certificati	4 Homioide	building, etc. (Specify)	i i marta de la como de la mo		City or Town, State)	nannar as stated
	thin 24 hour thin 24 hour thin 24 hour mpletely fill	(Check only one)	ner: On the basis of examination and menner stated.	and/or investigation, in my	opinion, death occurred at	the time, dete end place	, end due to the cause(s)
)	F 5 0 0	29b. Signature englished of certifier	Mara	29c. Licen	21928	augi	st 2nd koop
	5	30. Neme and actress of person who co Leonel Barahona,		a) (Type, Print)	Baltimore	, MD 21229	
	State	31. Date filed (Month, Day, Year)	32. Registra/s Signature		a. V.		

A Property of

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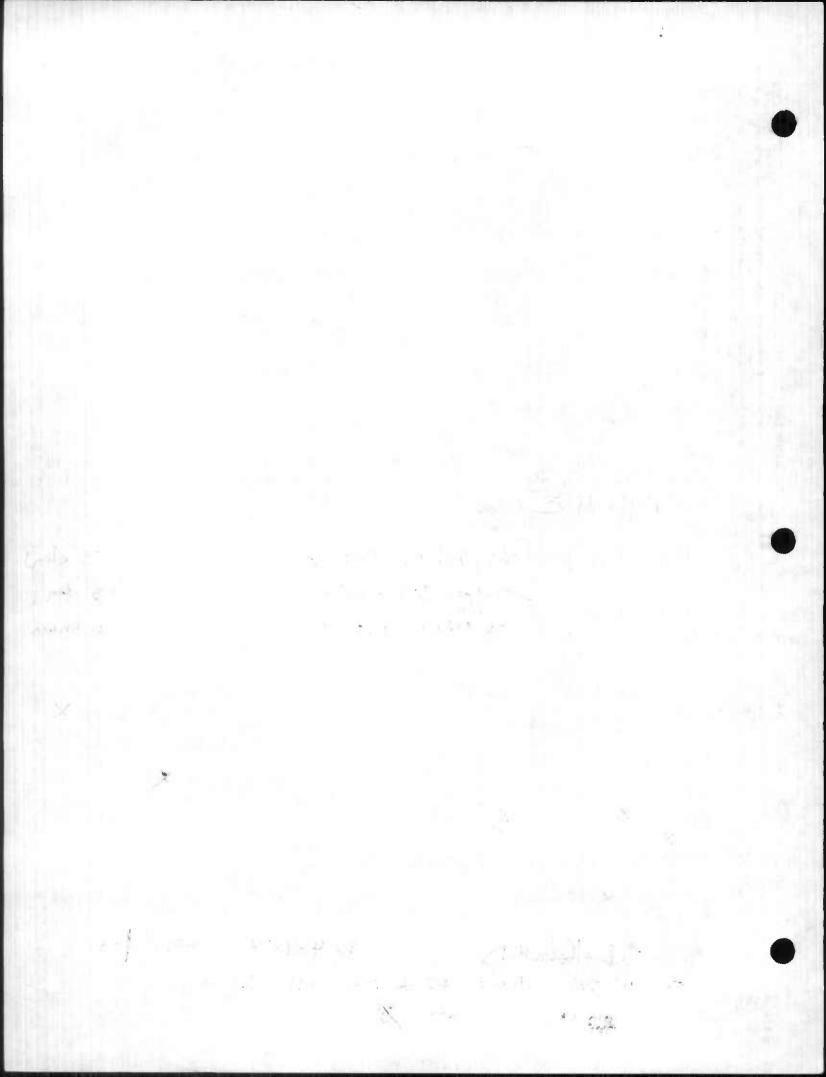
			Certificate of Death	Reg. No.								
Physician	Decedent's Name (First, Middle, Last) Dorothy	Millrose	Hull	2. Date of Death Month August 5, 200	3. Time of Death							
/Medical	4a Facility Name (If not institution, give street	et end number)	4b. City, Town, o	Location of Deeth 4c. County of								
	Frederick Health C	are Center 7. Age (In yrs. last bir	Frede		rederick							
Funeral Director	156-22-0307 1□ M	053 5 70	Yrs. Months Days Hours Min	B. Date of Birth Month Dev. Yeard December 28, 19	9. Birthplace (State or Foreign 2 Pounts) New York							
f show sidal	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi	10c. City, Tow	n or Location Frederick		10d. Inside City Limits 1 2 Yes 2 No							
th with the Maryla 23a or 28a-f shoutst be notified at rai Director	10e. Street and Number 1419 Hunting Horn L	ane	10f. Zip Code 21703	10g. Citizen of W	hat Country? U.S.A.							
urs after death st, or flame 22 Examiner mus by Furners	1 Never Married 2 Married	Was Decedent Ever in U,S. Armed Forces? □ Yes 2∯ No 1 Yes, Give Yeer or Detes:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1□ Yes 2√ No Specify:	(Specify Yes or No- orto Rican, etc.) 14. Rece Black Specify:	- American Indian, c, White, etc. White							
72 ho natural dical i	15. Decedent's Education (Specify only highest grede control		Decedent's Usual Occupation (Give kind of work done during most of w	orking 16b. Kind of But	siness/Industry							
yglene. Yglene. Ye the Me	Elementery/Secondary (0-12)	College (1-4or 5+)	'life. DO NOT use retired) Secretary	U. S. G	overnment							
Mental Hyg inked other aftic event, I To Be C	17. Fether's Neme (First, Middle, Last) Edward William		18. Mother's N	ame (First, Middle, Maiden Sumeme ry Louise Warren								
I should Mand Mand Mand Mand Mand Mand Mand Man		Rurel Route Number, City or Town,	Stete, Zip Code)									
ages 1 and 2 ant of Health t. If Itam 27 i	19a. Informent's Neme/Relationship (Type, Print) Joanna Mae D'Antuono/Daughter 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1419 Hunting Horn Lane, Frederick, Maryland 20a. Method of Disposition 20b. Placa of Disposition (Neme of cempatery, cremetory or other place) Smithsburg Crematory Aug. 7, 2000 Smithsburg,											
ath certificate be associed attending physician and for use as the burist-transit claryMedical Examiner	23a. Pert 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest d	Due to (or as a	consequence of):	ac or respiretory errest,	Interval Between Onset and Death							
0 00 0	Part II. Other significant conditions contribu	iting to death but not resulting in	n the underlying cause given in Pert I.		tribute to the cause of death							
5 80		120		1 Ves 2 No	Probably 4 Unknow							
aw requisite been 2 should				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
cata has to page 2 s				1□ Yes 2 No	1 Yes 2 No							
Physician: The this certificate ral director, page Co.: To Be Co.	25. Wes case referred to medical examiner? 1 Yes 2 No Hosp	1 ☐ Inpatient 2 ☐ ER/O	stpatient 3 DOA Other: Nursing	Home 5 Residence 6 Other 28d. Describe how injury occurr.								
r Attending ter death. Irector: After n by the fune rtification	1 Netural 5 Pending 2 Accident investigation 3 Strickles 6 Could not be		Time of njury et Work? M 1 Yes 2 No Irm, street, factory, offica	28f. Location (Street and Number City or Town, State)								
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination an	o, death occurred at the time, date and pla d/or investigation, In my opinion, death oc	ce, and due to the cause(s) and mac curred at the time, date end place, a	nner as atated. and due to the cause(s)							
To the To the comp	29b. Signeture and title of conflict	Myari M	29c. License number 0 D4755.	29d. Date signed	(Month, Dey, Year)							
	30. Name and address of person and complete William Johnson		(Type, Print) omas Johnson Drive,	#202, Frederick.	Md. 21702							
State	31. Date filed (Month, Day, Year)	32. Registrer's Signeture	& how	, , , , , , , , , , , , , , , , , , , ,	, -130 -227 -22							



State of Maryland / Department of Health and Mental Hygiene 00 261,00

			Cer	tificate of	Death	Reg. N	ło.	20403
D1 -1-1-1	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Dav Ye	3. Time of Death
Physician /Medical	Margar	et Hamill				ust 1	2000	7:40 PM
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or Location	on of Death	Ic. County of D	eath
<u> </u>	Frederick Memorial	<u> </u>			Frederick		rederi	
Funeral Director	220-12-7445	TAL ONE	rs. last birthday) 74 Yrs.	Months Days	Hours Min. (Date of Birth Month, Day, Yea D. 27, 1		Birthplece (Stete or Foreign Country) aryland
pue *	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limita
with the Maryland a or 28a-f ahow Les norting at	Maryland Frederick	. F	derick					1 ☐ Yes 2 ◯ No
vith the Ma tor 28a-fa be noutled	10a. Street and Number	TILE	derick	10f. Zip Code		10g. C	Citizen of What	Country?
3a or	5620-B Avonshire F	Place		21703		USA		
fler death v	11. Merital Status	12. Was Decedent Ever in	U,S. 13. W		Hispanic Origin? (Specify ban, Mexican, Puerto Rica		14. Race - A	merican Indian,
72 hours after naturel, or the area Exertine	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuc		n, etc.)	Specify:	Mite, etc.
d within 72 hours at gene. In then "neturel", or the "neturel", or the model example to by I	15. Decedent's Edu	cation	16a. Deced	ent's Usuel Occu	pation	16b.	Kind of Busine	
5 5	(Specify only highest grad	College (1-4or 5+)	life. D	O NOT use retire	during most of working ad)			
filed with Hygiene. The the the the the the the the the the t	12		self			ho	memake	r
THE S	17. Father's Name (First, Middle, Last)				18. Mother's Name (Fit	st, Middle, Maid	en Sumame)	
Menta Menta Price	Dennis Doyle				Mary Carr			
d 2 should be flik th and Mental Hy 7 is marked oth traumatic evant TO Be	19a. informant's Name/Relationship (T)		19b. Maiting	Address (Stree	t and Number or Rural Ro	ute Number, City	y or Town, Stat	e, Zip Code)
and ealth n 27	John Hamill, husba				ire Place, I			21703
of H H har	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ F	Removel from State	. Place of Dispos cemetery, crem	ition (Name of atory or other pla				or Town, State
Peg ment ant: lury	4 □ Donation 5 □ Other (Specify)	R	lesthaver					ck, Maryland
permit. Peges 1 a Department of Hee Important: if tem any injury or othe pnce.	21. Signature of Funeral Service Licens		00999 10	Name and Address 6 East	ess of Facility Keene Church Stree	ey and E et, Fred	erick,	Funeral Home MD 21701
	23a. Part1. Enter the disease, or comp shock, or fleet failure. List only o	lications thet caused the de						Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	Respire	to ry o (or as a consequence	faile	we			Onset and Death
sit sit		Kupe	real	cemic	X			13 day 1
n and ist-transit	Sequentially list conditions, if any, leading to immediate	bue to	(or as a consequ	ience of):				
ficete be ex physician is the buria	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	. ovar	an	mas	3			unknown
enflicete be exeling physician a e as the burial-	that initiated events resulting in death) Last	Due fo	(or as a consequ	ence of):				
es that the death cer igned by the attendir be detached for use by Physician/A	Part II. Other algnificant conditions co		esulting in the un	derlying cause gi	iven in Part I.	23b. Did tobac	co use contrib	outs to the cause of death
res that the designed by the a libe detached find by Physic						1 Yea	2 No 3	Probably 4 Unknow
s been s 2 should pleted						24a. Was an au performed		4b. Were autopsy findings available prior to completion of cause of death?
The law page 2						1 🗆 Yes	210 No	1 ☐ Yes 2 ☐ No
certificate rector, pag	25. Was case referred to medical				26. Place of Death (C)			
Physician: this certific ral director. TO Be (ayaminer?	Hospital:	☐ ER/Outpatient	3 DOA OI	ther: 4 Nursing Home		6 □Other (5	Specify)
ding Phy th.: After this funeral	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. tnju		Describe how in		
To the Hospital or Attanding Physician: T within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p. Medical Certification: To Be C.	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, streecify)	et, factory, office	281.	Location (Street City or Town, St.	end Number o	r Rural Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of my k ner: On the basis of exami end manner stated.	nowledge, deeth	occurred at the testigation, in my	ime, dete and place, end opinion, deeth occurred e	due to the cause t the time, date a	(s) and manne and place, and	r as stated. due to the cause(s)
To the within To the comple	29b. Signature and fitte of certifier			29c. Licen	se number	29d I	Date signed #	fonth, Day, Year)
F 5 F 8	170161	MIN		D	48184	5	5/21	00
	30. Name and address of person who co	ompleted cause of death (It		Print)		1701		
	501 W 7Hh	511007		rick	MD 2	1101		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1	1			

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 0005,01 Fac 12:16A M JEH-/Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** HOPKINS HOSPITA RALTIMORE CITY if Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 8. Sex 1/20 M 2□ F Birthplace (State or Foreign Country) **Funeral** 18 VORK. 159-68-6770 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Modinal Examiner must be notified at 1 Yes 2 No Funeral Director YORK DALLASTOWA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 332 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritel Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or her eny injury or other traumatic event. Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) STUDENT Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be W. 2 LICHAEL SAIL 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 19e Informant's Name/Reletionship (Type, Print) MICHAEL W ALLAS 14 touk 20b. Place of Disposition (Name of commatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State Deta 4 ☐ Donation 5 ☐ Other (Specify) DUSGIEHANNALEM. GARGENS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. 23a. Part1. Enter the disease companies shock, or heart failure. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final SEPSIS disease or condition resulting in death) Examiner Examiner with burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest pue Due to (or as a consequence of) be axec Box 68760 ettending physician Physician/Medical the Due to (or as a consequence of) signed by the ette Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2000 1 Yes 1 Yes 2 No this certificata 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Attending 5 Pending investigation 1 Naturai 1 Yes 2 No deeth. 2 Accident i or Attend after deeth Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Rospital of the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piace, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dei 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . WOLFE

STIBALTIMORE MD 2128]

DHMH 16 Rev 6/95

State

Registrar

where en

31. Date filed (Month, Day, Year)

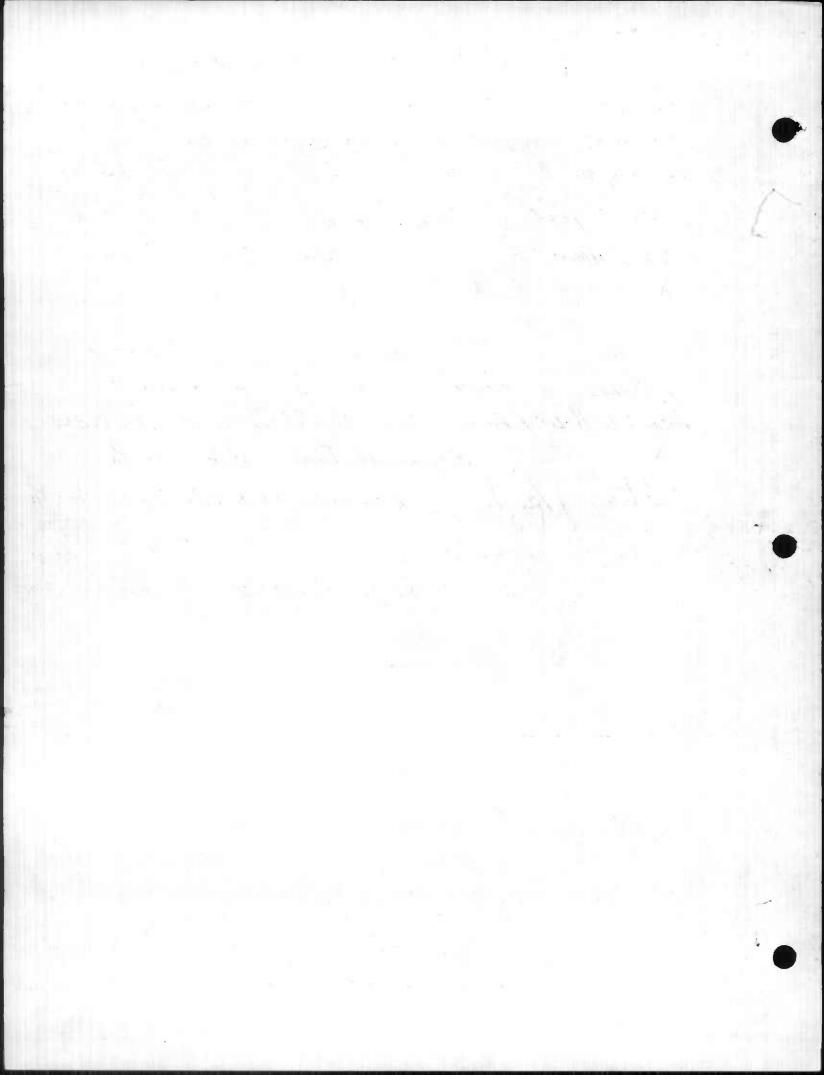
AUG 1 9 2000

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32. Registrar's Signature

Severan

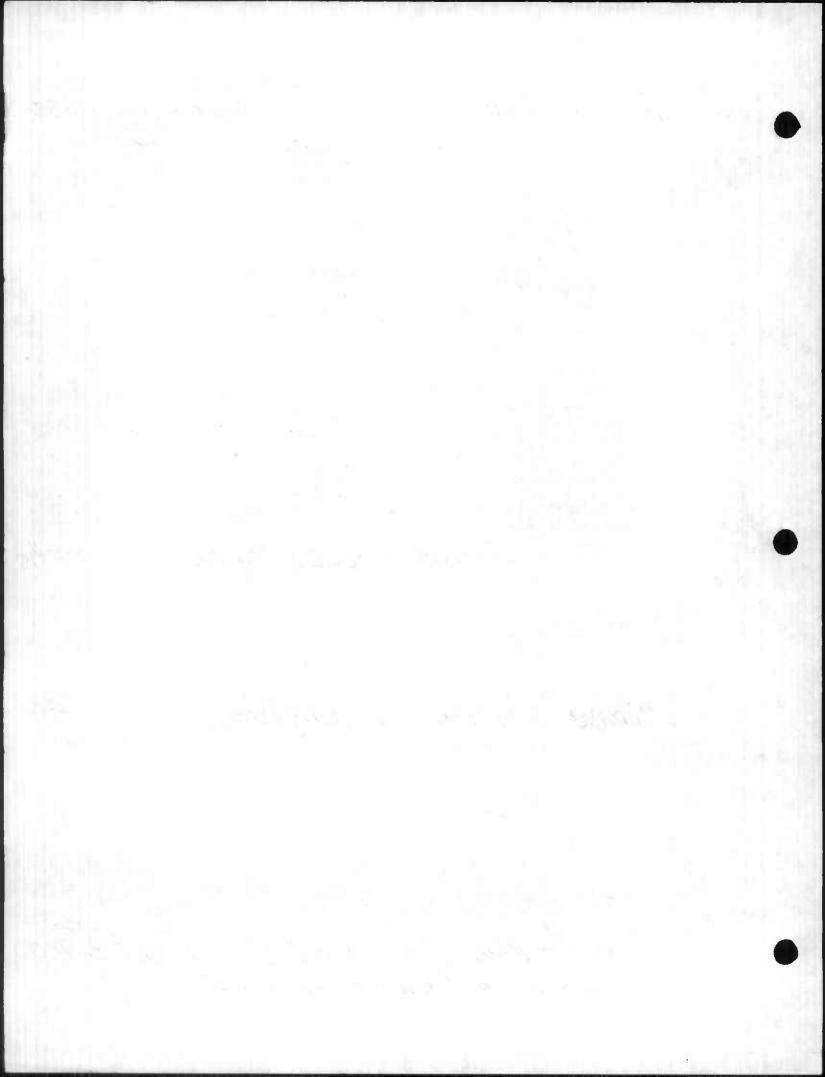


State of Maryland / Department of Health and Mental Hygiene amend item 24a per phys. G786 8/230/00 yf Certificate of Death

00 26411

					Oen	ilicate of	Deatti	I a D	Reg. No.		a Time of Booth		
Physician		. Decedent's Nama (First, Middla, La	1/0	Lac	_			2. Date of De	Day	Yaer	3. Tima of Death		
/Medical	ı L	revence	Haw	LE 2	>		45 Ch. Tour cal	Husus	Td a	2000	0030		
Examiner	r 4	e Facility Neme (If not institution, given	re street and number)				4b. City, Town, or l		4c. County	of Death			
		Howard County				Williaday (Vans	Columbi						
Funeral	5		Sex 7. Ag No⊒M 2□ F	ga (In yrs. la		If Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Dr	th ly, Year)	9. Birthplac	e (State or Foreign		
Director		319-30-4236	A 201		68 ^{Yrs.}			April 21,1932 England					
		Jsual Residence of Decedent 0a. State 10b. County	10c. City, Town or Location							10d	inside City Limit		
23a or 28a-f sho ust be notified at ral Director		7.000								1.00.	1 ☐ Yes 2000		
28a-t s collified	Į.	aryland Howard	1	<u>E</u> .	llicot			-					
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S 1 S		9910 Carrigan I	or.		21042				United States				
iber must Funeral	1	1. Marital Status	12. Was Decedent Armed Forces?	12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puarto R		pecify Yas or No D Rican, atc.))- 14. Rac Blac				
F. Ban		1 Never Married 2 Married	1 ⊠ Yas 2 □ No If Yes, Give			1 ☐ Yes 2 ☑ No Specity:			Specify:				
E E	3	3 Widowed 4 Divorced	Year or Datas:	alas:Korea									
ygiene. ser than "natur t, the Medical. Completed	510	15. Decedent's E (Specify only highast gr	ducation ada completed)	16a. Decede	 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 			16b. Kind of Business		itry			
and on	2	Elementary/Secondary (0-12)	College (1-4or	College (1-4or 5+)		Actuary							
Co Lega	3		4						-		ty Admir		
H and H		7. Fathar's Nema (First, Middla, Last	")				18. Mother's Nan	ne (First, Middle	, Maiden Suman	10)			
Men artice		Frank Hawkes Kitty Vea											
alth and 2 sho alth and 3 27 is me or fraums		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
		Ramsay Hawkes / s	spouse			Carriga	n Dr. E	llicott	City, M	D. 21	21042		
五種	2	Oa. Mathod of Disposition			Place of Disposition (Name of cametery, crematory or other pla		ce)	Data	20c. Location ·	20c. Location · City or Town			
TY OF THE		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci			ro Cror			Aug. 3	Catonsville, Mar		Maryla		
tra .	1	21. Someture of Funeral Servica Lice	nsee		letro Crematory 22. Nama and		ass of Facility	2000					
OF FR		10			Ha	arry H.	Witzke's	Family	Funeral	Home,	Inc.		
10000	+	mologic 4112 Old Columbia Pike Ellicott City, MD, 21043											
	1	23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death											
hysician /Medical	- 1		m.	1.10-	1.1:					/	· marial		
xaminer	1.0	Immediata Cause (Final diseese or condition resulting in death)	a ///E	TUS	tatio	1410	nocon	CINUM		0	MONTH		
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nding physician and use as the burial-transit	Z :	Sequentially list conditions,		Dua to (or	as a consequ	ence of):							
ourie E		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C										
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e as	2		d										
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ed by the atterdet for u	5 F	Part II, Other significant conditions	contributing to death t	out not resul	ting in the und	derlying cause give	ven in Part I.	23b. Did	tobacco use co	ntribute to th	ne cause of deat		
7 E	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tot Annual Discuss 01 ve									3 Probat	bly 4 Unkno		
signed by d be deta		Cilivilic	01/3/10	ical	VC/	WIIWI	ary vi.	and c		year 2000 0530 unty of Death IOWard 9. Birthplace (State or For Country) England 10d. inside City Ling 1 years of What Country? ted States Race - American Indien, Black, White, etc. ecity: White of Business/Industry I Security Adminimane) own, State, Zip Code) MD. 21042 ion City or Town, State nsville, Maryla al Home, Inc. t City, MD, 210 Approximate Interval Between Onset and Death State City, MD, 210 Approximate Interval and Death Onset			
shoul	3	24a. Was en eutopsy performed?											
	-									comp of de	ath?		
page ?								10	Yes 21 No	10)	Ves 2□ No		
certificate has irector, page 2 Be Comp		25. Was case referred to medical					OC Divers of Day				05 20110		
director,	5 1	axaminar?	Hospital: 19 Tripatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
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within 24 hours after death. To the Fureral Director: After completely filled in by the funeral Medical Certification:	5 1	1 Natural 5 Pending	(Month, Da	y Year)	Injury	28c. Inju Wo		200. 2000100	now injury boom	100			
the the	6	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No		on (Cleant and Number of Print) Part At		2-1-1-1-1		
tree n by		4 Homicide determined	200. PIQUE ULIT	iury - At hon ic. (Specify)	ne, farm, stre	et, factory, office			wn, Stete)	per or murai m	foure rumber,		
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n 24 hours after dead the Ference Director: pressy filled in by the edical Certificat	3	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	hysician: To the best miner: On the basis of	of my know	riedge, death	occurred at the ti	me, date and place opinion, death occu	, and due to the	ceuse(s) and make, date end place,	annar as state and dua to th	ed. ne cause(s)		
the place	46.	one)	and manner st	ated.									
To the comple	2	29b. Signature applitter of certifier	m	2		29c. Licens	se number	-/	29d. Date signe	d (Mortin, Da	y, Year)		
		1/10/12	-1111.1			1/4	0178		14/191	ST	5,200		
15	3	30. Name and address of gerson was completely cause of death (flegs 23a) (Type, Print)											
1-		11055 LAHO ANTWORT PHILLY (NIMBIA-MO 21041)											
Circle		11. Date filed (Month, Day, Year)	32. Regist	rar's Signate	ure /	1 W	unin			17			
State Registrar	4			Same?	40	Ann 4	11						
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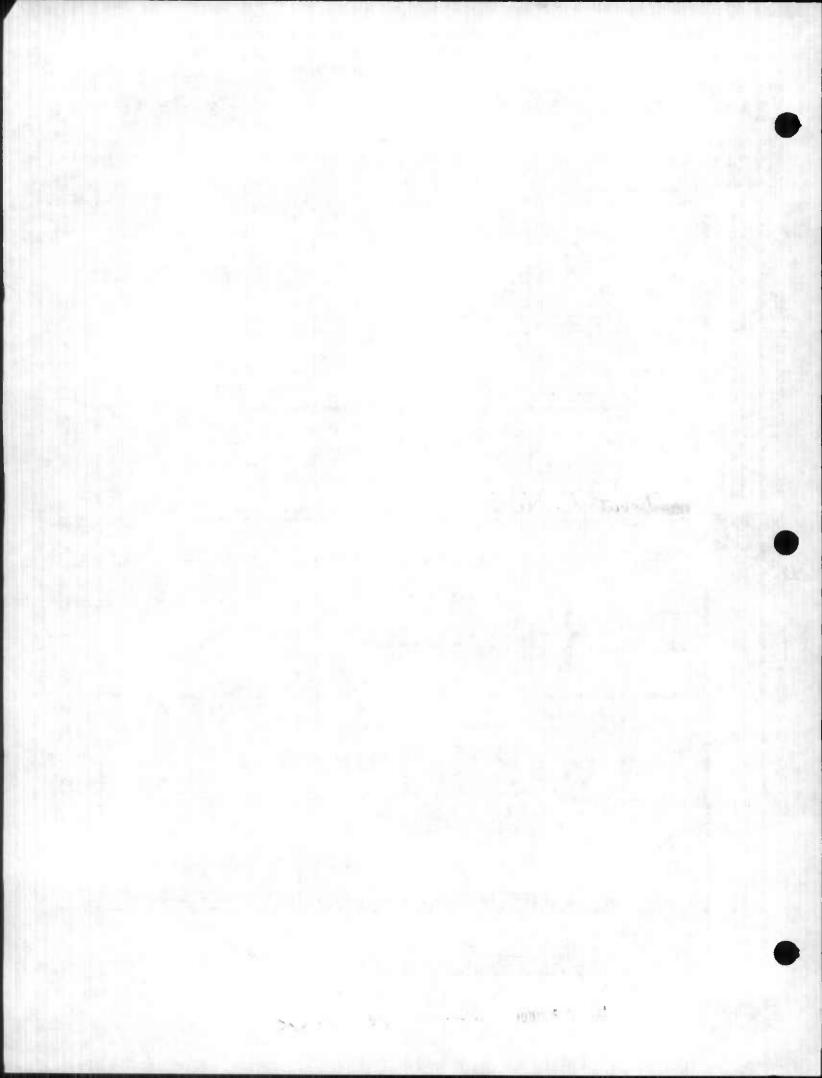


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				Ce	rtificate of	Death		Reg. No.	1 4	0414		
1. Decedent's Nem	INE E	JONE	3				2. Date of De Month	Day 07	Year	3. Time of Death		
### 4a Facility Name (### UN U 5/2 Fall 5. Social Security	4a Facility Name (If not institution, give street and number) 4b. City, Town, of Marky LAND Husel The SALT 5. Social Security Number 6. Sex 1 M 2 XF 62 4b. City, Town, of the Under 1 Year of Under 1 Year of Under 24 Hours of the Under 1 Year of Under 24 Hours of the Under 1 Year of Under 1 Year							th y, Year) 1938				
Usual Residenca o	10b. County					1	0d. Inside City Lin					
10a. State Maryland 10e. Street and Nu 3700 Ri 11. Marital Status		1					1 ☐ Yes 2X					
					10f. Zip Code				10g. Citizen of What Country?			
11. Marital Status 1 Never Mari	3700 Ridge Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Examed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:				If Yes, specify Cuben, Mexican, Puerto				U.S.A. so or No- etc.) 14. Raca - American Indian, Black, White, etc. Specify: White			
	15. Decedent's E	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of worl ed)	king	16b. Kind of B	usiness/Inc	dustry					
Eiementary/Sec	ondary (0-12)	College (1-401 5+)	Medi	cal Secr	etary		Physici	ans (Office		
17. Fether's Name			ruder			The same of the sa	ne (First, Middle, Maiden Surname) Viola Fox					
19a. Informant's N			rauer	19b Maili	no Address (Stree	et and Number or Ru			State. Zip	Code)		
	Jones -		d			load, West				21157		
20a. Method of Dis	position		20b.		osition (Name of matory or other pi		Date	20c. Location				
	☐ Cremation 3 i 5 ☐ Other (Spec		State		Memoria		8/11/00	Rockvil	le, 1	Maryland		
Sequentially list or if any, leading to it ceuse. Enter Und Cause (Disease or that initiated event resulting in death)	erlying Injury	c	Hypa	or es e consec	100)							
Part II. Other signi	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.								23b. Did tobacco use contributa to the cause of c			
by Pt												
Completed								an autopsy ormed?	ev	ere autopsy findi ailable prior to mpletion of caus death?		
CO							10	Yes 2 XND	1 [Yes 2 No		
25. Wes case refe exeminer?	rred to medicel	Magnital			10	26. Place of Dea	th (Check only	one)				
1 Yas 2 27. Manner of Dea		Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (S							(y)			
1 2 Natural 2 Accident	latural 5 Pending Investigation	(Mon	28a. Date of Injury (Month, Day Year) 28b. Time of Unjury Injury M 28c. Injury at Work? 1 Yes 2 No.									
27. Manner of Dea 1 Relatural 2 Accident 3 Suicide 4 Homicide	6 Could not determine	209. Place	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one)		miner: On the b				time, date and place opinion, death occu						
29b. Signature and	I title of certifier	2				29c. License number		29d. Date signed (N		Day, Year)		
12	30. Name and address of person who completed cause of death (Item 23a)								8/7/00			
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Registrar

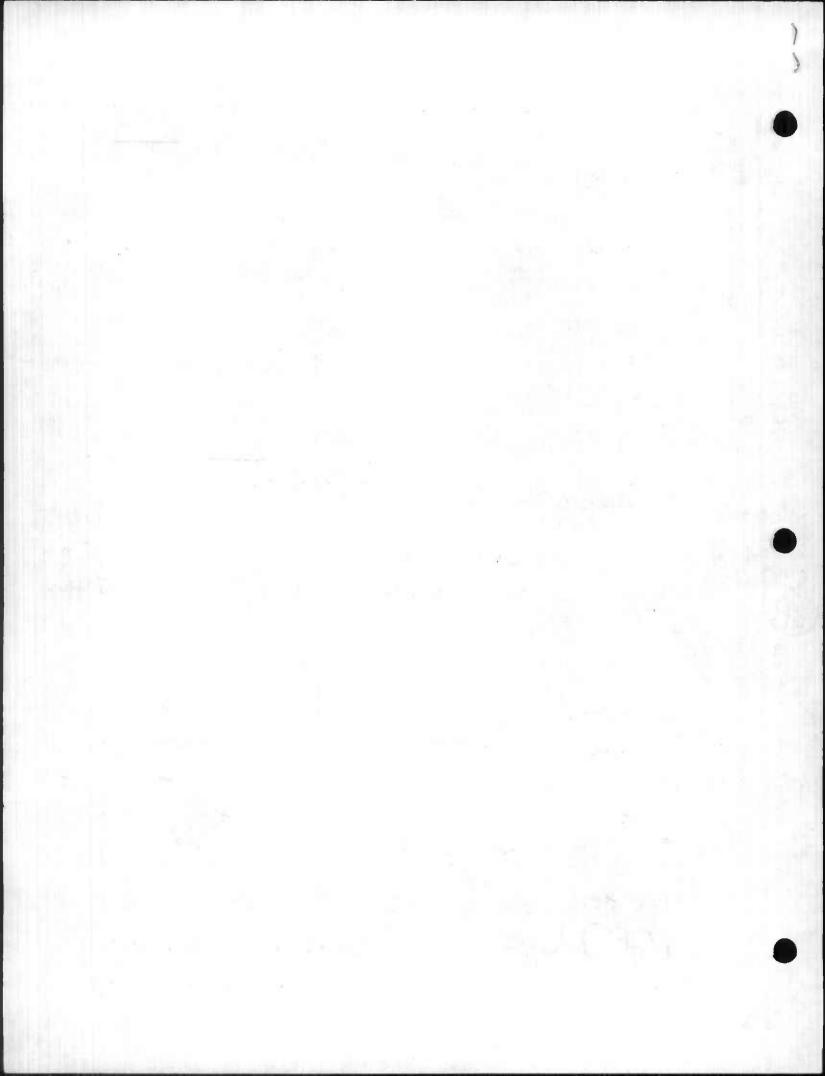


	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 00 25113											
Physician /Medical	1. Decedent's Name (First, Middle, Last) Charlotte Jankowiak 2. Date of Death Month Day 7 2000 11:50 PM											
Examiner Funeral Director	4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death Frederick 5. Social Security Number 070-09-6352 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 9. Birthplace (State or Foreign Country) Months Days Hours Min. Aug. 14, 1908 New York											
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits											
vith the Man t or 28s-f et be notified Director	Maryland Frederick 1 □ XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?											
23 E	15.78 Carey Place 21701 U.S.A. 11. Merital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Married											
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Baltimore, Maryland 2121 semit, Pages 1 and 2 should be filed within speciment of Health and Mental Hydiene, mportant; if Item 27 te marked other than " nny Injury or other treumatic event, the Me ands. To Be Comple	12 Seamstress M. Wile Company 17. Father's Name (First, Middle, Last) Frank Jankowiak Catherine Cieslak											
- 0 a = =	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Baltimore, IV	Joseph H. Wisniewski (Nephew) 1578 Carey Place, Frederick, Maryland 21701 20e. Method of Disposition 20e. Method of Disposition 1 Buriel 2 XCremetion 3 Removel from State 20b. Place of Disposition (Neme of cemetery, crematory or other place) Smithshurg Cremetery.											
Baltimore, pemil, Pagas 1 a Department of He Important: If item eny injury or othe page.	4 Donation 5 Other (Specify) Smithsburg Crematory 8/9/00 Smithsburg, Maryland 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701											
Box 68760, death certificate be executed death certificate be executed be attending physician and ad for use as the burial-transit usician/Medical Examiner	23a. Part 1. Enter the disease, or complications that used to the provided by the shock, or heart failure. List only one cause on the provided by the shock of heart failure. List only one cause on the provided by the shock of the provided by the p											
O. of the	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Chronic demantia (Sever) Alzheimer: 1 Yes 2 No 3 Probably 4 Unknown											
cords, v requires to require stand been sign should be letted by	24a. Was an autopsy performed? 24b. Were autopsy findings evallable prior to completion of cause of death?											
= F # 8 0	ARTELIOSCLERATIC CARDIO - VASCULAL DISSAGE 1 Yes 2 No 1 Yes 2 No 25. Was cess referred to medical examiner?											
of other this ald district T.	1 Solitation Hospitation Hospitation 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of											
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DIVI To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)											
0 48 4	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) FREDERICK Transfer or Hospital											
State Registrar	GEORGE 1. Shirth M.D. VICE-PRES HEDICAL AFFAIRS PREDERICA, MO; 21701 31. Date filed (Month, Dev. Year) 32. Registrer's Signature 4											

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Items 4c, 20b per F.D. State of Maryland / Department of Health and Mental Hygiene 08/04/2000, Carroll County, wjl Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima ol Death Month Year Physician Magdalen KIPKE. 6:KAM 03 2000 08 /Medical # Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Y Aug. 23, 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 2034 Arrington Road Carroll 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Year) 917 1□M 20F 82 Yrs. 217-05-150 Director Maryland Usual Residence of Deceden the Manylend 10a State 10b County 10c City Town or Location 10d. Insida City Limits or items 23e or 28e-f show MD Carroll 1 ☐ Yes 2√ No Director Marriottsville 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2034 Arrington Road 21104 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, Whita, atc. 72 hours efter 1 ☐ Never Married 2 X Married "natural", or l Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry be filed within 7 tal Hygiena.
d other than "n Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12 Homemaker 17. Father's Nama (First, Middle, Last) 16. Mother's Nama (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt. mant of Heelth and Mental Hy lant: if Item 27 is marked oth lury or other traumatic avent George A. Jaeger Grace Zepp 19a. Informant's Name/Relationship (Type, Print) (Spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mr. Richard J. Kipke, 2034 Arrington Road Marriottsville, MD 21104 20b. Place of Disposition (Nama of cematary, crematory or other place) 8/8/2000 20c. Location - City or Town, Sta -7/5/2000 Sykesville, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal Irom State permit. Page Department of important: if any injury or page. Lake View Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): HSr. Hation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician the burta Physician/Medical Dua to (or as a consequence of): The lew requires that the death certificate signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0 1 Yes ZUNo 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed BRad Conur 1 Yes ₹ No 1 Yes of Vital Physicien: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 22 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Division NA NA or Attending NA deeth. 1 TYes 2 No NA 2 ☐ Accident sfler deetl Director: 3 Suicide 6 Could not be determined 28a. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral Di completaly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 08/03/2000 200 23117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersha acorrelaun Blud mo Landran M.D. 690 31. Date filed (Month, Day, Year) 32. Registrar's Signatura AUG 0 4 2000 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death KARANDJEFF **Physician TRMA** DELORES AUGUST 11:45 AM 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Yeer 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2\ F Days Hours Min. Yrs. Director 348-16-9674 Nov. 23, 1925 Illinois Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County 1 ☐ Yes 2 No Directo Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 11713 Barnswallow Place 21774 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Specify: White 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 self artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ent of Health and Mental H-t: If Item 27 is marked oth y or other traumatic even. Clarence Windsor Goodwin Viva Delores Neville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Karen Carrier, daughter 5005 Killen Court, Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages hent of h 1 Burial ZXCremetion 3 Removal from State important: I any injury o goos. Smithsburg Crematory 8/7/2000 Smithsburg, Maryland 21 Signature of Faneral Service Lige 22. Name and Address of Facility Keeney and Basford Funeral Home M00999 106 East Church Street, Fre 23a Part Enter the disease, or complications the clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. 106 East Church Street, Frederick, MD 21701 Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical VASCULASE ACCIDENT 5 DAYS Examiner Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): edical Due to (or as a consequence of) Box Physician/M P.0. Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part f. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Records, à 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was en eutopsy performed? Completed 2X No 1 ☐ Yes 💥 No 1 ☐ Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Menner of Death 1 Naturaf 2 ☐ Accident 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: 3 Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completaly filled edicai 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DZ1936 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNSON DE SMITE 100, FREDERICK DONE LSON MO 170 THOMAS 31. Date filed (Month, DAUG) 32. Registrer's Signature State

DHMH 16 Rev 6/95

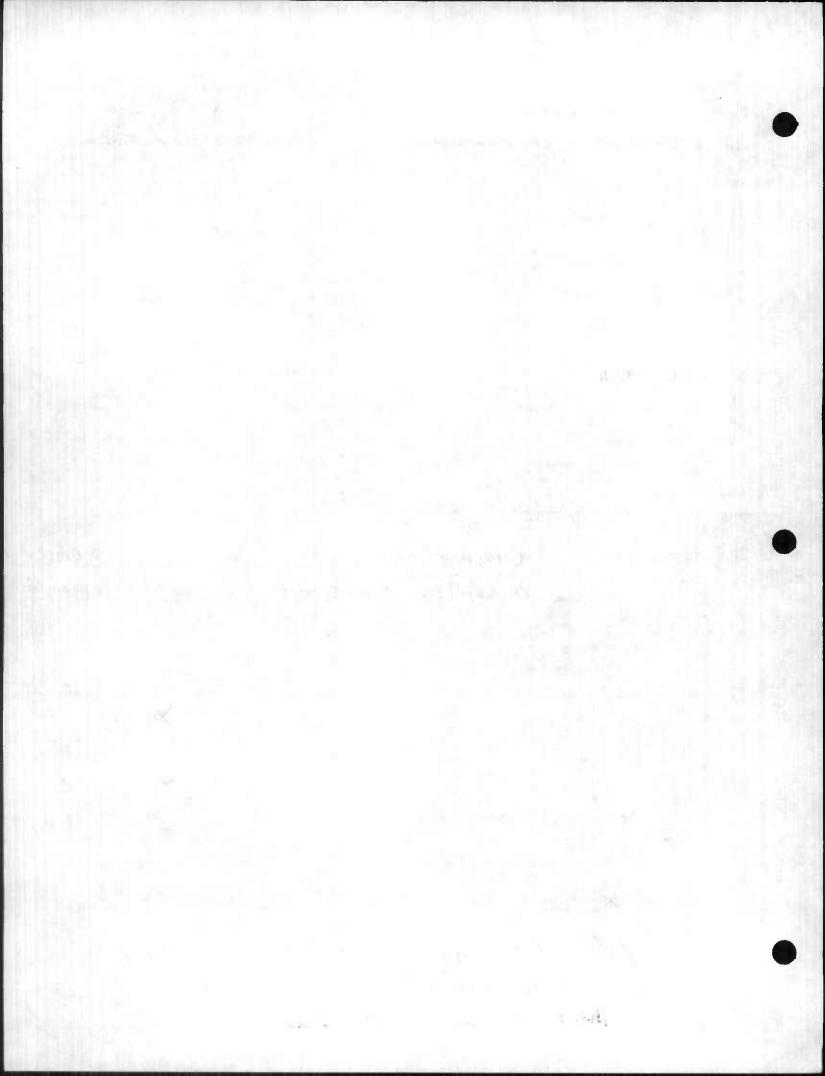
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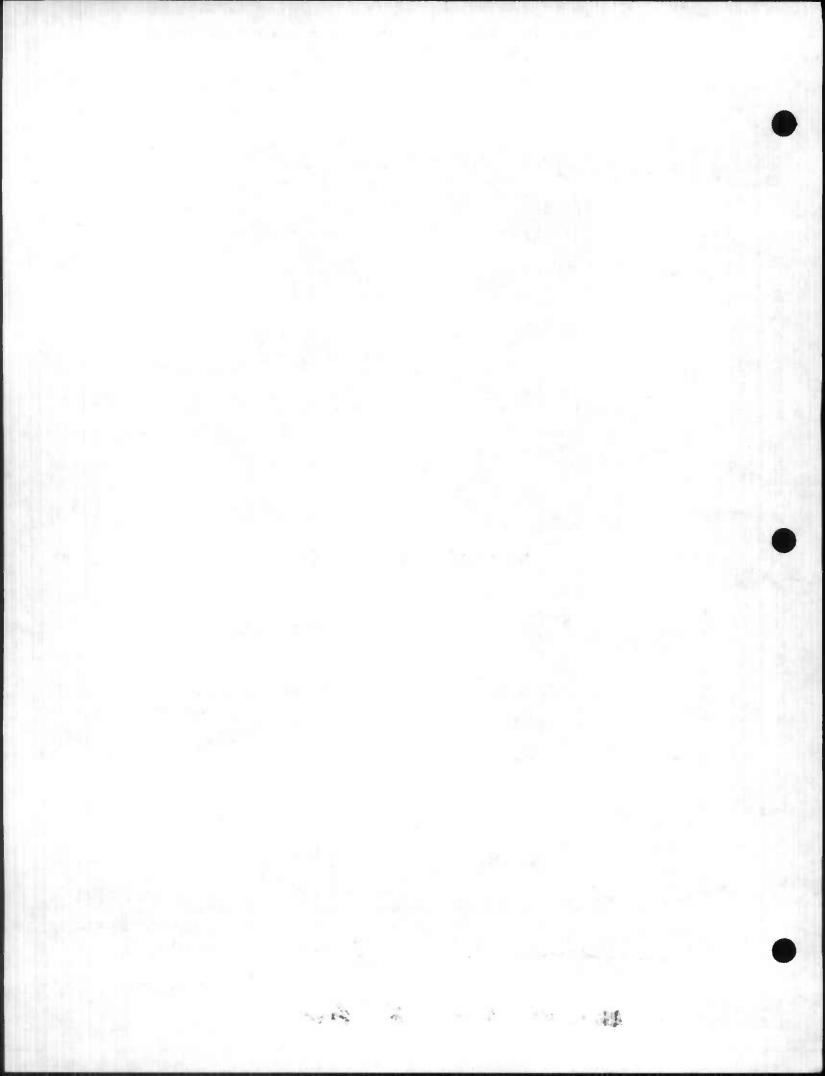
			Certifica	ate of Death		Reg. No.	0 20310
	1. Decedent's Name (First, Middle, La	st)		X	2. Date of D		3. Time of Death
Physician /Medical	JOSEPH KG	ERN			8	Day 3	2000 1005 PM
Examiner	4a Facility Name (ff not institution, give	re street and number)		4b. City, To	wn, or Location of Dea	,	
	UNIVERSITY	OF MARYL	AND	BAL	TIMORE		TIMORE
Funeral Director	5. Social Security Number 2 2 7 - 1 5 - 7 5 0 2	Sex 7. Age (In yr.	o. rest ontridely/	der 1 Yeer if Under hs Days Hours	24 Hrs. 8. Date of 8 Min. NOVI	irth Pay, Year) 971	9. Birthplace (State or Foreign Country) V a .
2	Usual Residence of Decedent						
the Maryland 28a-f ahow notified at ector	10a. Stete 10b. County	AND THE RESERVE AND THE PERSON NAMED IN	City, Town or Location				10d. Inside City Limits
the Minorities Control	Md. Freder	TICK B	runswick				
0 0	10e. Street and Number 537 Brunswick	Street	10f.	21716		10g. Citizen of V	What Country?
Ď ,	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Orl pecify Cuban, Mexican MNo Specify:		14. Rec Bla Specify	ce - American Indian, ck, White, etc. White
ygiena. ner than "natur nt, tra Madeal. Completed	15. Decedent's E (Specify only highest gra	ade completed)	16a. Decedent's U	sual Occupation work done during most Tuse retired)	t of working	16b. Kind of B	usiness/Industry
then the	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	Duct W			Const	ruction
	17. Father's Name (First, Middle, Last)	1 5400 11	1	er's Name (First, Middl		
ental H	Raymond Rucke	er Kern Jr.		Chai	rlotte Pa	tricia	Werking
marke marke	19e. Informent's Name/Relationship (19b. Mailing Addr	ess (Street end Number			
ith ar	C. Patricia Ke	**					, MD 21716
Hea	20a. Method of Disposition	206	Place of Disposition (Name of	Date	T	City or Town, Stata
ortant: If h	1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	(y)	dagerstow		ory8/5/20	00 Ha	gerstown, MD
Departm Importa any inju pnce	21, Signafule of Funeral Service Licer	1. Willies	John	T. Will Swick, Mi	iams Fune	eral Ho	me
huoloian	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	eth. Do not enter the n	node of dying, such as	cerdiac or respiratory	errest,	Approximate Interval Between Onset and Death
hysician /Medical xaminer	Immediate Cause (Final disease or condition	CHOLAN	16IT15				2 DAYS
	resulting in death)	Due to	(or as a consequence		1_	2016	2 DAYS 8 MONTHS
n and sel-transit	Sequentially list conditions	b. PANCREA	(or as e consequence				8 10(070 1713
ng physicia as the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	(or es e consequence d	of):			
for for		d					
d by the letached	Part Ii. Other algnificant conditions of	contributing to death but not re	esulting in the underlyin	g cause given in Part i		Yas 2	ontribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
should should					24a. Wa	is an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
page 2					10	Yes 2000	1 Yes 20€Ne
certificata h rector, page	25. Was case referred to medical			26 Place	of Deeth (Check only		13.00
his certific il director, To Be	examiner?	Hospital: 1 Dippatient 2	□ ER/Outpetient 3□	Other:	ursing Home 5 Re		ner (Snecity)
After th luneral tion:	27. Menner of Death 1 Preserved 5 Pending investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describ	e how injury occur	
within 24 hours after death. To the Funeral Director: After to completely filled in by the luners. Medical Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At building, etc. (Spec	home, farm, street, fec cify)	tory, office	281. Location City or T	(Street and Numi own, State)	ber or Rural Route Number,
n 24 hours ne Funeral pletely filled		ysician: To the best of my kr niner: On the basis of examinand manner stated.					
Med Med	29b. Signeture and title of	1111		29c. License number		29d. Dete signe	d (Month, Day, Year)
5 F 0	> Talle	I llow MI	0	P1338	86	81	3/00
	30. Name and address of person who	completed cause of death (Its		TBAIT!	nore N	000	201
	31. Date filed (Month, Day, Year)	32. Registrar's Sig		10000	1000	1	
State Registrar	AUG O	7 2000		10-			



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of	wayian		tificate of	Death		Reg. No.	0	26417
	Physicia		1. Decedent's Nam-	e (First, Middle,	Last)					2. Dete of De Month	ath Day	Year	3. Time of Death
1	/Medica		Edward	Kau	ffman, Sr					August	2	2000	2:10 a.m.
	Examine	er			give street and num	ber)		(S) = 3	4b. City, Town, or				
	•		169 Fai 5. Social Security N	rfield		Ano /lo um	last histodaya	If Under 1 Year	Frederic			deric	
L	Funeral Director		220-54-3 Usual Residence of	587	1 M 2 F	7. Age (In yrs. 49	Yrs.	Months Days		8. Date of Bin (Month, Da 4-25			place (State or Foreign ntry) ryland
	show dat		10a. State	10b. County		10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits
	the M	Directo	Maryland	Frede	rick	Fr	edericl	1					1 Yes 2 No
			10e. Street and Nur					10f. Zip Code			10g. Citizen of V		
	Pa 23	Funeral	169 Fair	field D	rive 12. Was Deced	dant Ever in U	.S. 13. V	Vas Decedant of	Hispanic Origin? (S	pecify Yes or No	United - 14. Rac	Stat e - Amario	
020	our our	by	1 Nevar Marri		Armed For	ces? 2 No		Yes, specify Cut	Hispanic Origin? (Sean, Mexican, Puan Specify:	o Rican, atc.)		Black, White, etc. Specify: White	
5-0	72 ho	eted	(Spec	15. Decedent's	Education grada completed)		16a. Deced	ent's Usual Occu	pation during most of wo	rkina	16b. Kind of Bi	usiness/in	dustry
Maryland 21215-0020	Man	Completed	Elementary/Seco		College (1-	4or 5+)	life. E	OO NOT use retire	e Receive		Prod	11100	
9			17. Father's Nama	ast)	V	varenous	1	na (First, Middle,					
lan	lid be lental lised of	To Be	Leonard	Napolo	on Kauffm					s Pauli	ne Voene	v Va	uffman
lany	and M		19a. Informent's Ne			au	19b. Mailin	g Address (Stree	t and Number or Ri				
	and and and and and and and and and and				n/ Wife		169	Fairfie	ld Drive		ick Mar	ylan	d 21702
altimore	I tot H If ther or oth		20a. Method of Disp 1 Burial 2		Removal from S		Place of Disposematery, cran	sition (Name of natory or other pla	ice)	Date	20c. Location -	City or To	own, State
tim	ramen ramen		4 Donation						Cemetery	8-5-00	Monrov	via,	Maryland
Ba	Depa Impo Impo Impo		21. Signature of Fu	guille	D I/1	1	St	Name and Addr auffer I	uneral H	omes, P.	Α.		
		4	V		omplications that ca	used the deat	16	21 Oposs	umtown P	Ike, Fre	derick,	Mary	land 21702 Approximate
	Physician		shock, or hea	rt failure. List o	omplications that canly ona ceuse on as	ich line.	n. Do not ont	51 1110 1110 da 01 0)	ing, oddin oo danda	o 01 100p.10101 y 0			Interval Between Onset and Death
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3	Examiner		resulting in deeth)		a. ITTE		or as a conseq	uance of):	Canio				0 111
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	ate be executed hysician and the bunal-transit	Examiner	Sequentially list co- if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate		Due to (c	r es a conseq	uence of):					
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	de s	edical	resulting in death) I	Last		Due to (0	r as a consequ	Jence OI):					
Вох	attending for use a	Physician/M			d							1	
	the atter	300	Part II. Other signif	icant condition	s contributing to dea	ath but not res	ulting in tha ur	nderlying cause g	iven in Part I.	23b. Dld	tobacco use co	ntributs t	o the cause of death?
P.0										10	Yes 212 No	3 □ Pro	bably 4 Unknown
ds,	requires the	D D								24a Was	en eutopsy	24b. W	ere eutopsy findings
Records,	been s	Completed by							161	perfo	rmed?	av	ailable prior to impletion of cause death?
Re	The law ate has page 2	E C								10	Vas 2000		Yes 2□ No
tal	delan: The cartificate rector, pag	Se C	25. Was case refer	red to medical					26. Place of De	ath (Check only			
1	000	0	examiner?	No	Hospitel: 1 🗆 In	patiant 2	ER/Outpatien	1 3 DOA O	hor-	lome 5 PResi		ner (Specia	(y)
0	Affar th funeral		27. Manner of Death	h 5 🗆 Pending	28a. Dete o (Month	f Injury n, Day Year)	28b. Time of Injury		iry et ork?	28d. Describe	how injury occur	red	
Sio	Attending ir death. actor: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	Investige 6 ☐ Could no	ation				Yes 2 No	00/ 1/	Character of the said		/ Courte Number
Division of Vital	or At after Direct in by	Certification:	4 Homicide	determin	200. Place	g, etc. (Specif	ome, tarm, stre	eet, factory, office		City or To		oer or Hun	al Route Number,
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	2525	edical	(Check only one)		kaminer: On the bas and mann	sis of examina							
	To the To the company	Σ	29b. Signature and	title of certifier	1 1	4.5		29c. Licer	se number		29d. Date signe	d (Month,	Day, Year)
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			30. Nama and address Ehan		ho completed cause SKancle		50 (Type,	Print) 1 W T	14 Stree	+ Fred	erick r	1D :	21701
	State Registra	5	31. Date filed (Moni	th, Day, Year)	32. Re	gistrar's Signa	itura	. do	all!				

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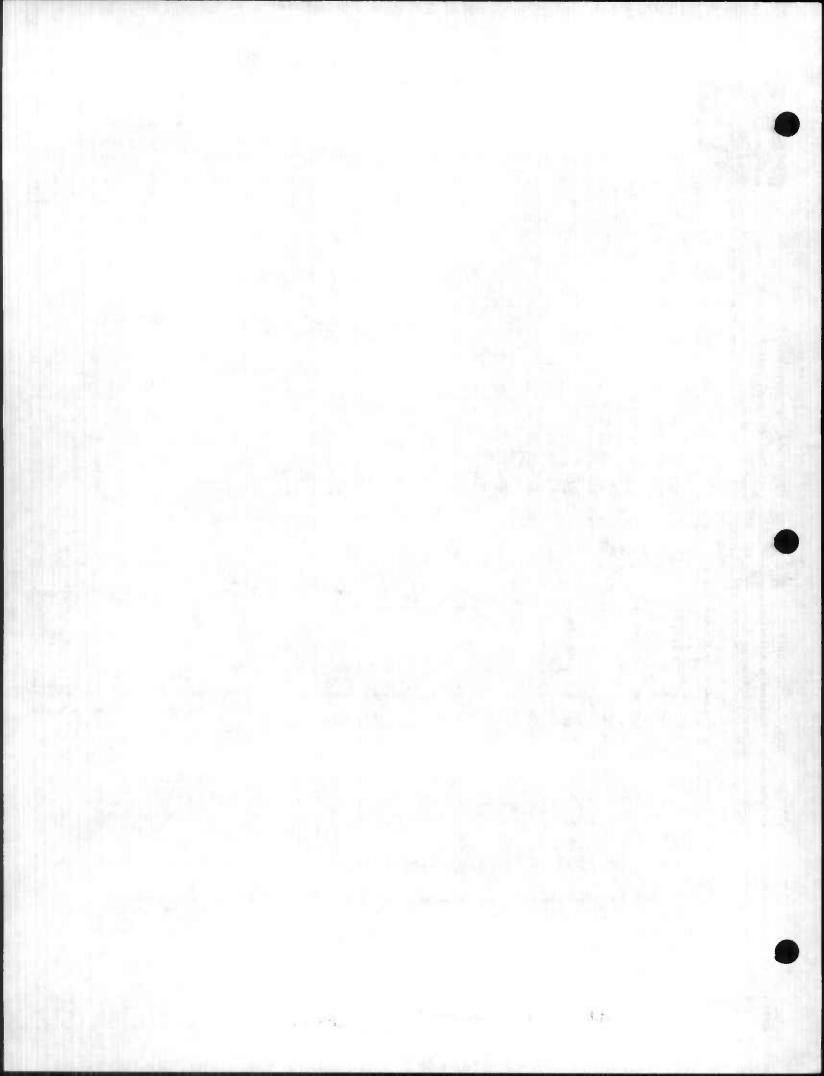


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

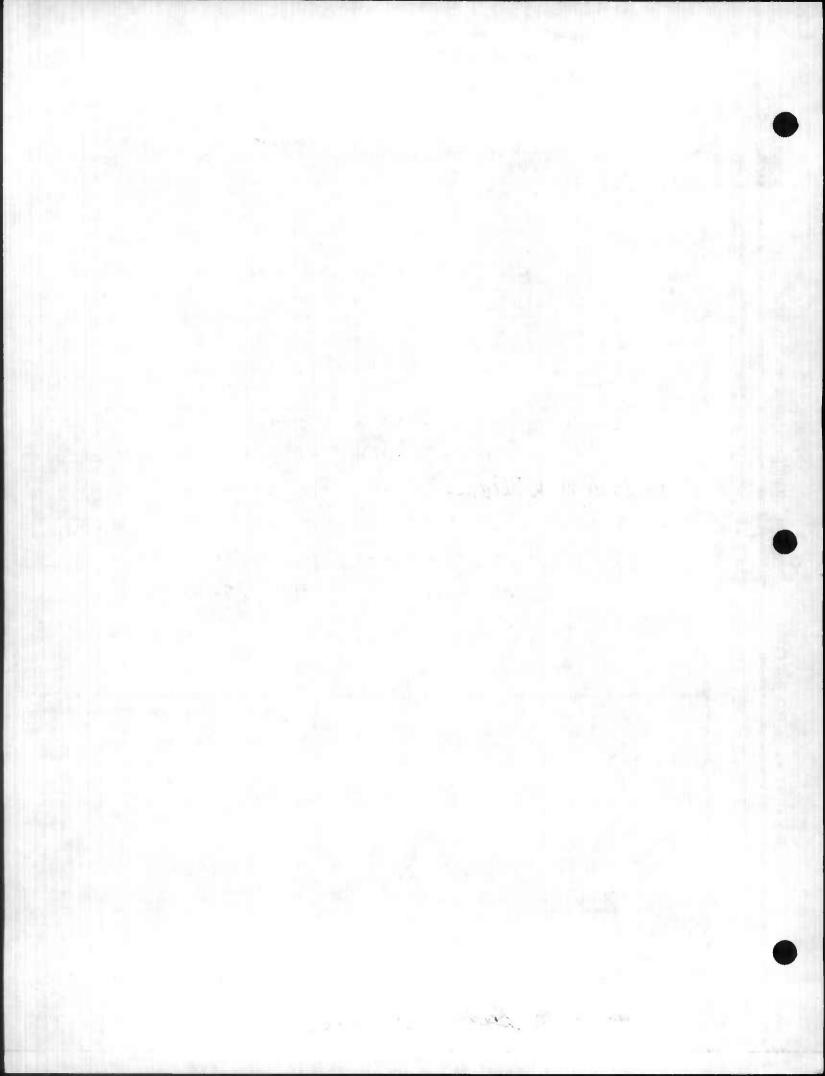
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				Cer	lincale of	Deam		Re	eg. No.		
Physician /Medical		che May L						2. Date of Death Month Aug. 6	, ^{Dey} 2000	Yeer	3. Time of Deeth 10:30 PM
Examiner	4a Fecility Name (If not Institution, g Frederick Men						m, or Local	ation of Death	4c. County	of Death	k
Funeral Director			7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day, Apr. 10	Year)		leca (State or Foreign
th the Maryland or 28s-f show a notified at Director	Usual Residence of Decedent 10a. State 10b. County MD • Fre	ederick	10c. City, T		eation Cymar					1	0d. Inside City Limits 1 ☐ Yas 2 ☑ No
or zile-t sh be notified. Director	10e. Street and Number	n.1			10f. Zip Code	04 7 5		16		n of Whet Country?	
r hams 23s instrmat! Funeral	11430 Renner	12. Was Deced		13. V	Vas Decedent of Yes, specify Cul	21757 Hispanic Original, Mexican	gin? (Spec	city Yes or No- lican, etc.)	U.S.A. 14. Reca - American Indian, Bleck, White, etc.		
Enam.	1 ☐ Never Married 2 ☐ Married 2 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Da	9	1	□Yes 2 XNo	Specify:		Specify: White			ite
ad within 72 ho ygiene. we than 'natura', the Medical.	15. Decedent's (Specify only highest of Elementery/Secondery (0-12)	Education trade completed) College (1-		6a. Deced (Give life. D	ent's Usuel Occu kind of work done OO NOT use retin	during most ed)	of working	g	16b. Kind of Bi		dustry
Mental Hygin Mental Hygin rhad other I file event, th	17. Father's Neme (First, Middle, La Kirby Ashby Pri		homemaker own home 18. Mother's Name (First, Middle, Meiden Surname) Elizabeth Pearl Dodson					10)			
and 2 show aith and N 127 is man or trauman	19a. Informant's Neme/Relationship Mary M. Chapman				g Address (Stree Renner				City or Town, 21757		Code)
Pages 1 or ment of Ha ant: If them uny or oth	Mary M. Chapman (Sister) 20e. Method of Disposition 1 M Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 N Burlal 2 Permation 3 Removal from State 4 Donation 5 Other (Specify) 11430 Renner Rd., Keymar, MD. 21757 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery 8/9 Frederi										
Departition of the partition of the part	21. Signeyum of Funeral Service Lic	DAK		I	Name end Addr Onald B 1 E. Ma	. Thom	pson	Funeral	lHome	2176	69
Physician /Medical Examiner	23a. Part : Enter the disease, or so shock, or heart failure. List on Immediate Cause (Finel disease or condition resulting in deeth)	on ceuse on ee	nused the deeth. It is the line. Nelmo Due to (or as	nitis						e	Approximeta Intervel Between Onset and Death Fow Day s. Fow Yvan
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he etter	Part II. Other aignificant conditions	contributing to dea	ath but not resultin	g in the ur	denying cause g	iven in Part I.		23b. Dtd to	bacco usa co	ntribute to	the cause of death?
requires that the death been signed by the ette should be detached for leted by Physicia	C·V·A. De	lydrate	on, c	ubac	ente 6	owel		1 D Y	es 2 No	3 Prol	
	Dockruchen							24a. Was en		av.	ere autopsy findings ailable prior to impletion of cause death?
certificate has rector, page 2 sirector, page 2 sirector,	25. Was case referred to medical					26 Place	of Dogsh	1 ☐ Ye		10	Yes 22 No
Physician: this certific ral director,	axaminer? 1 Yes 2 No	Hospitel:	patient 2 ER	/Outpatien	3 DOA	her:	W	e 5 Reside		ner (Specif	y)
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To the Hospital or Attentivith 24 hours after death of the Funeral Director: completely filled in by the Medical Certifical	Suicide 4 Homicide 28e. Place of Injury · At home, farm, street, factory, offica 28e. Place of Injury · At home, farm, street, factory, offica 28f. Location (Street and Number or Run City or Town, State) 28e. Place of Injury · At home, farm, street, factory, offica 28e. Place of Injury · At home, farm, street										
To the Hospital within 24 hours or To the Funeral I completely filled		nysician: To the bas and manne	sis of examination								
To the To the comp	29b. Signeture end title of certifier	my	^	N	10 5 180	se number			9d. Date signe	100	
	30. Name and address of person wh 31. Dete filed (Month, Day, Year)	ASUBD	of death (Item 23		oll Ho	nza i	AVE	FRE	90ERIC	KI	UD 21701



State of Maryland / Department of Health and Mental Hygiene 00 251, 10

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/Medical Examiner	40		If not Institution, g		d number)			4b. City,	Town, or	Location of Dea	1	c. County		
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uneral lirector		102-16-	2830	. Sex 1□ M 2X3	V_	rs. last birthday, 4 Yrs.	Months Da				av. Year.	916	YUKOT	laca (Stata or try) 1, PA
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A C	17.		ther's Name (First, Middla, Last) ichael Myers			TTOTAL	mancı	18. Mc	18. Mother's Name (First, Midd					-
o Be		Michael	Myers					J	ohani	na Cochr	an			
-	19	a. Informant's N	ame/Relationship	(Type, Print))	19b. Mail	ling Address (St	reet and Nu	mber or F	lural Route Num	ber, City	or Town,	State, Zip	Code)
17.1		Bruce J	. Merrit	new. So	on	5615	Glen H	111 C	ourt	, Jeffer	son,	, MD	2175	55
y or othe	208	a. Method of Dis 1 X Burial 2	position Cremation 3	Removaif	201	cematery, cra	position (Name of amatory or other 'Y'S Cen	place)		Date 8/9/00			City or To	
y inju	Bruce J. Merrin 20a. Method of Disposition 1		ense //	llittne		22. Name and A		iams	Funeral					
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State of Maryland / Department of Health and Mental Hygiene

26420

			Certifica	ate of Dea	ath	F	Reg. No.	0	20420
D1	1. Decedent's Name (First, Middle, Las				2.	Dela of Dea Month	lh Day	Year	3. Time of Death
Physician /Medical	Mary Lou	Overton			A	ug 3	2000	100	120 am
Examiner	4a Facility Name (If not institution, give	a street and number)		4b. City	y, Town, or Locati	on of Death	4c. County	of Death	
uneral irector	Asbury Solom 5. Social Security Number 450 28 6707		last birthdey) If Und	er Sol dar 1 Year If Ur is Days Hou	urs Min.	Date of Birth (Month, De)	(, Year)		
	Usual Residence of Decedent 10a. State 10b. County Maryland Calver	10c. Cit	y, Town or Location					10	od. Inside City Limits
tiffed ctor	marytanu carver		71011101110						1 ☐ Yas 2 No
terns 23s or 23s-f sho her must be notified at uneral Director	100. Street and Number Asbury	Circle		Zip Code 20688			10g. Citizen of W United	hat Count Sta	ites
by by	11. Merital Status 1 Nevar Married 2 Married 3 November 1 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yas 2 No If Yes, Give Year or Detes:	If Yas, s	cedent of Hispanic pecify Cuban, Me 2 No Spe	xican, Puerto Rici	Yes or No- an, etc.)	Blac	- America k, Whita, e Whit	itc.
r, the Medical Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Us (Giva kind of	sual Occupation work done during use retired)	most of working		16b. Kind of Bu	siness/Indi	ustry
e Me	Elementary/Secondery (0-12)	College (1-4or 5+)	housewi				own h	ome	
	17. Father's Name (First, Middle, Last)	2 +	nousewi	-	Nother's Neme (Fi	irst, Middle,			
o Be	Jerry Boone J	ohnson			ary Ca				
T	19a. Informant's Name/Reletionship (1) Carey O. Randa	Type, Print)	19b. Mailing Addre	ess (Street end M	umber or Rural R	oute Numbe	or, City or Town,	State, Zip	Code)
nt: If ham 2 ry or other	20a. Method of Disposition 1 Pauriel 2 Cremelion 3 4 Donetion 5 Other (Specify	Removel from State Wa	Plece of Disposition (A cometery, cremetory of IKer Cha	verne of		Date	20c. Location - Arlingt	City or Tov	wn State Virginia
any inju	21. Signature of Euroral Service Licen	500		end Address of F	R				Home PA
sician edical	23a. Part1. Entar lhe disaasa, or com shock, or heart feilure. List only Immediata Cause (Final	olications that caused tha deet one ceuse on eech line.	h. Do not enter tha m	oda of dying, suc	th as cardiec or re	spiretory er	rest,		Approximate Interval Between Onset and Death
miner	diseasa or condition resulting in deeth)		eumonia	of):					1 week
in and ial-transit Examiner		b		.0.				1	
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	C	or as a consequenca o	л).					
9 8	that initiated evants resulting in deeth) Last	Due to (o	r es a consequence o	f):			114		
of for use	Dot II Other algorities at any distance	natribution to death but out on	ution in the contaction	i i- F	Port I	22h Dia s	obacco usa cor	delbusta to	the causs of death?
ed by the attending detached for use y Physician/	Part II. Other eignificant conditions or	ontributing to death but not res	ulting in the underlyin	g cause given in F	Pan I.		res 2 No		ably 4 Unknown
should be							an autopsy med?	ava	re autopsy findings illable prior to nplation of cause death?
page 2						101	as 2000	10	Yes 2 No
rector, par Be Co	25. Was case referred to medical examiner?				Place of Deeth (C	heck only o	ne)		
his al di	1 ☐ Yes 2 ☐ No		ER/Outpatient 3		Mursing Home		-)
ther the	27. Manner of Death 28a. Deta of Injury (Month, Dey Year) 28b. Time of Injury at Work? 1 Yes 2 No. 28c. Injury at Work? 1 Yes 2 No. 28c. Injury at Work?					now injury occurr			
ol Director: All led in by the full Certification	4 Homicide determined	28e. Placa of Injury - At he building, etc. (Specif	ome, ferm, street, fect y)	treet, fectory, office 28f. Location (Street end Number or Rurel Route Number City or Town, Steta)				r Houte Number,	
completely filled in		yelclan: To the best of niy kno niner: On the basis of examine and manner steled.							
Somp	29b. Signature and title of certifier	W. Bennett	56	29d. Dala signed (Month, Day, Year) August 3, 2000					
	1								
	30. Neme and address of person who of Charles W. Ben	completed cause of death (Item	an Rd.	Lusby I	MD 20	657	- 1		

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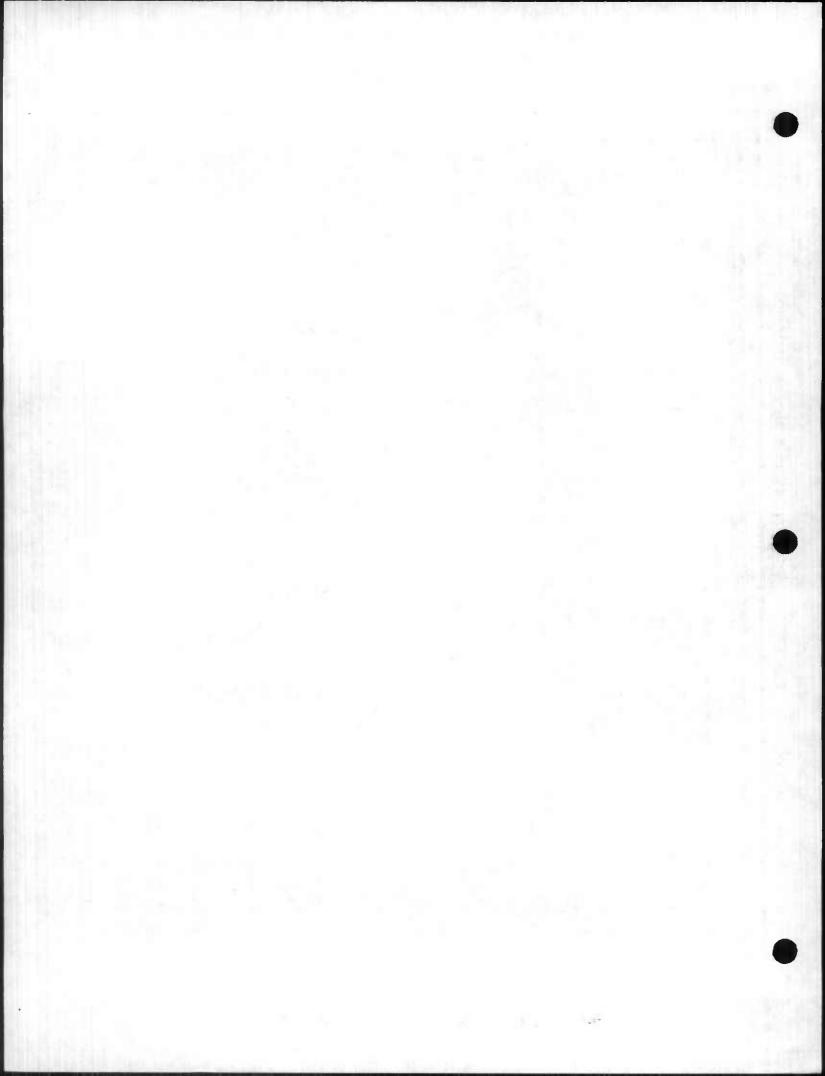
State of Maryland / Department of Health and Mental Hygiene

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an al	Decedent's Nerr		BERT	WILE	Y	PALM	ER			Dete of Dee Month	Day 5 200	Year	3. Time of Deat
er	te Facility Name	(If not institution, g	ive street and nu	mber)			4		wn, or Locati				
	A	tlantic	General	Hospita	al				rlin		Worce	este	r
5	5. Social Security I		Sex	7. Age (In yrs.		/) if Unde Months	Days	If Under Hours	24 Hrs. g.	Dete of Birth (Month, Day	Year)	9. Birth	place (State or Forentry)
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1-	Usuat Residence of 10a. State	10b. County		10c C	ity, Town or L	ocation							10d. fnside City Lin
0	MD	Worce	ster	100.00	Ber1								1 ☐ Yes 275
Director	10e. Street and Nu	ımber				10f. Zij	Code				10g. Citizen of V	Vhat Cou	ntry?
	2 W	hite Sai	1 Circle	9			2	1811			U.S.	U.S.A.	
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1 by	3 Widowed	4 Divorced	Yeer or D	Detes: 1936	-67	100	2,0110	ороспу.			эреспу	. 1	white
Completed	(Spe	15. Decedent's	Education		16a. Dec	edent's Usu re kind of wo DO NOT u	el Occup	etion during mosi	t of working	16b. Kind of Business/Industry			
Jdr.	Elementery/Sec		College (The second	life.						II C	AT	
8	12					snip	SW	riter			U.S. I		
œ l	17. Father's Name	A STATE OF THE STATE OF		Lmer	18. Mother's Name (First, Middle, Maidel							1	
2	M					anche		pbel.					
	19e. Informent's Neme/Relationship (Type, Print) 19b. Meiting Address (Street and Number or								er or Rural Re	oute Numbe	r, City or Town,	State, Zij	o Code)
on a Therman of The Company and The Company an	Barbara Lee Palmer-wife 2 White Sail Circle, Bo									7			
	20a. Method of Dis	sposition Cremation 3	□Removet from	State 20b.	Plece of Disp cemetery, cre	position (Na ematory or	me of other plac	e)		Dete	20c. Location -	City or T	own, Stete
		5 Other (Spec		State	lisbur				8+7-2	2000	Salisbu	ry Ma	aryland
	21. Signature of	unerel Service Lic	ensee			22. Name e	nd Addre	ss of Facilit	y Thom	as Fu	neral H	ome :	PA
	1 ×e	weth	R. 71	-	9 7	700 Lo	cust	St.			D 21613		
	23a. Part1. Enter shock, or her	the disease, or co	mplications that	caused the dee	11					_			Approximete
	shock, or he	ert failure. List on	ly one ceuse on (each line.								1	tnterval Between Onset end Deat
	Immediate Cause		11-	limth	. 6	indi	1.5					1	Sund
	disease or condition resulting in death)	on	e. 4 6					C.,				1	accords -1
9			7.	Lenie	or as a cons	equence or)	M					1	٧.
E			b		or as e cons	- m	ulry.	Wy.				1	Upa
Exa	Sequentially list co if any, leading to it cause. Enter Und Cause (Disease or	onditions, mmediate	-	Due to (Or as a const	equence of		3 -				- 1	6-
Cal	Cause (Disease of that initiated event	r Injury	c	Levina	or as e conse	13	Sur.						LLANA
/Medical Examiner	resulting in death)	Last		Due to (t	or as e corrse	aquerice or)							
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80	ran II. Other algni	mcant conditions	11	eath but not res	sutting in the	underlying	cause giv	en in Part I	•				bably 4 Unk
6	Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.									10,	TES ZLINO	3 L Pro	DEDIY 4 M UNK
y Ph	KMA	WILL.	urun										
d by Physician	KMA	FILM.	Urun							24a, Was	an eutopsy	24b. W	/ere autopsy findi
leted by Phy	KMA	FILM.	WW.							24a. Was perfo	an eutopsy med?	81	vailable prior to ompletion of cause
mpleted by Phy	KMA	fal min	With the second							perfo	med?	CI	vailable prior to ompletion of cause death?
Completed										perfo	rmed?	CI	vailable prior to ompletion of cause
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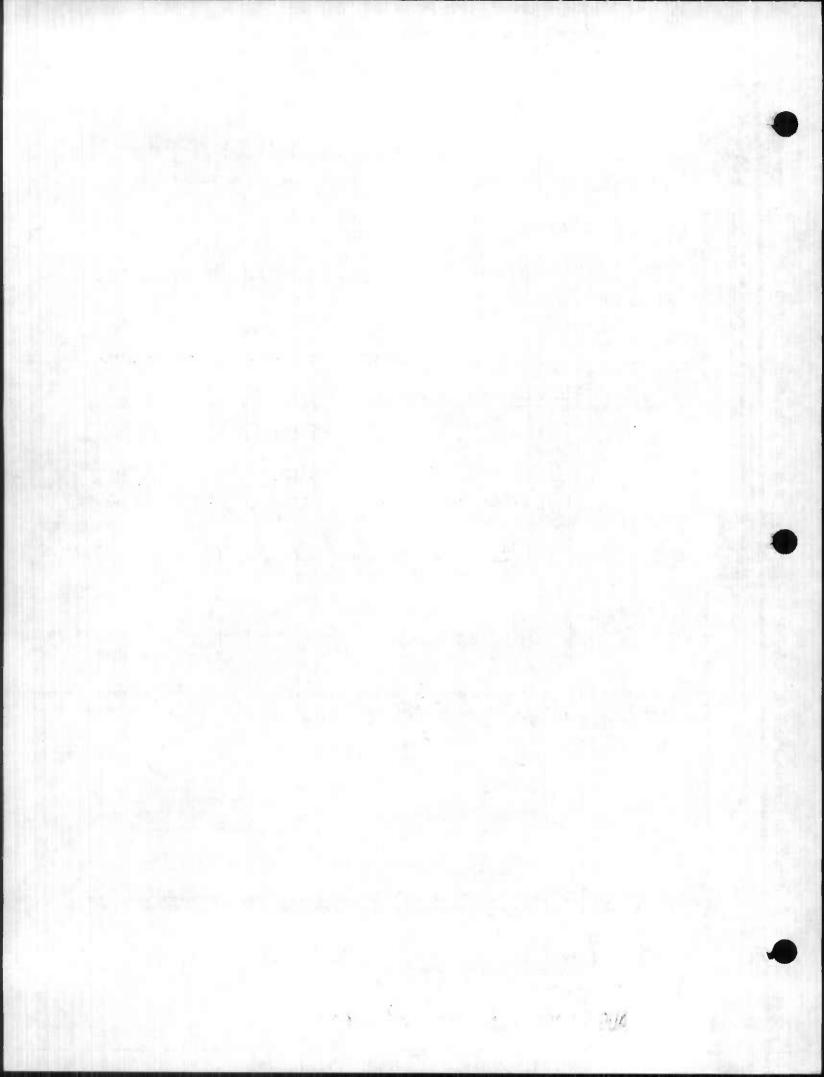
State of Maryland / Department of Health and Mental Hygiene 00 26422

				Cert	ificate of	Death		Reg. No.	20422
		1. Decedent's Name (First, Middle, Last)		CIKCE			2. Date of D		3. Time of Death
	Physician /Medical	Lewis Howard Put	man				August		
λ_{1}	Examiner	4a Facility Neme (If not institution, give s	street and number)	- 130		4b. City, Town	, or Location of Dea	th 4c. County o	f Death
		College View Cen	ter			Frederi			erick
	uneral irector	5. Social Security Number 6. Sex 215-26-8978 Usual Residence of Decedent	7. Age (In yrs. 70	Yrs.	If Under 1 Year Months Days		Min. (Month, D	irth ay, Year) 5, 1930 1	9. Birthplace (State or Foreign Country) Maryland
laryland	show idat	10a. Stete 10b. County		y, Town or Loca				17.75	10d. Inside City Limits N☐ Yes 2 ☐ No
2	or 25a-1 at be notified Director	Maryland Frederic	k Fr	ederick	10f. Zip Code			10g. Citizen of Wi	**
6	sa or salt be r	403 Lee Plac			217			United S	States
020 ours after do	Examiner in by Fune	11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates: 51-5	11	as Decedent of I Yes, specify Cub		17 (Specify Yes or N Puerto Rican, etc.)		- American Indian, , White, etc. White
21215-0020 d within 72 hours at plene.	W. the Medical I	15. Decedent's Educ (Specify only highest grade Elementary/Secondery (0-12)	cetion e completed) College (1-4or 5+)	16a. Decede (Give k life. De mainte	ent's Usual Occup ind of work done O NOT use retire	pation during most o d)	f working	16b. Kind of Bus	
D BE	svent, Be C	17. Father's Name (First, Middle, Last)		marite	nance	18. Mother's	Name (First, Middle		the state of the s
rylan	To B	Lester William P		100 10 10	Add /04		K. Hahn	has Oite as Taura G	Note To Code
Ma	Tis n	19e. Informant's Name/Reletionship (Ty) Kathy Cioffi / sis					or Rural Route Numi		
O Tan	am 2	20a. Method of Disposition			ILLLOWQA ition (Neme of etory or other pla		Apt. 13,		City or Town, State
TO THO	y or o	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Mem. Ga		8/8/00	Frederic	le MD
altin alti	injur	21. Signature of Funeral Service License							Homes. P.A.
m 48	1.8) Jaiquelino.	2. Kreb						
		23a. Pert 1. Enter the disease, or complications, or heart failure. List only on		n. Do not enter	the mode of dyi	sumtown ng, such as ce	Pike, Fr	rederick, arrest,	Approximate
/M	sician edical miner	Immediate Cause (Final disease or condition resulting in death)	Mult	ople	Di	lu	an I	ulieli	Interval Between Onset and Deeth
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Records	2 should						24a. Wa	s an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
	page page						10	Yes 2 No	1 Yes 2 No
Vital	certificate rector, pag	25. Was case referred to medical examiner?					f Death (Check only	one)	
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2 2	Ter no	27. Manner of Death 1 ☑Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			how injury occurre	d
Division or Attending other death.	al Director: After the diners of in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At he building, etc. (Specify	ome, farm, stre		Yes 2 No	28f. Location	(Street and Numbe own, State)	or or Rural Route Number,
Hospital 24 hours	To the Funeral Director: A completally filled in by the fundal Medical Certification		ician: To the best of my kno ner: On the basis of examina and manner stated.						
To the	To the	29b. Signature and title of certifier	1 C/L ~	1.)	29c. Licen	se number	1/	Date signed	(Month, Day, Year) 7 2000
		30. Nama and address of person who co		23a) (Type, P	rint) lair Ave	T C	rederick,	MD 2170)1
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State of Maryland / Department of Health and Mental Hygiene 00 25123

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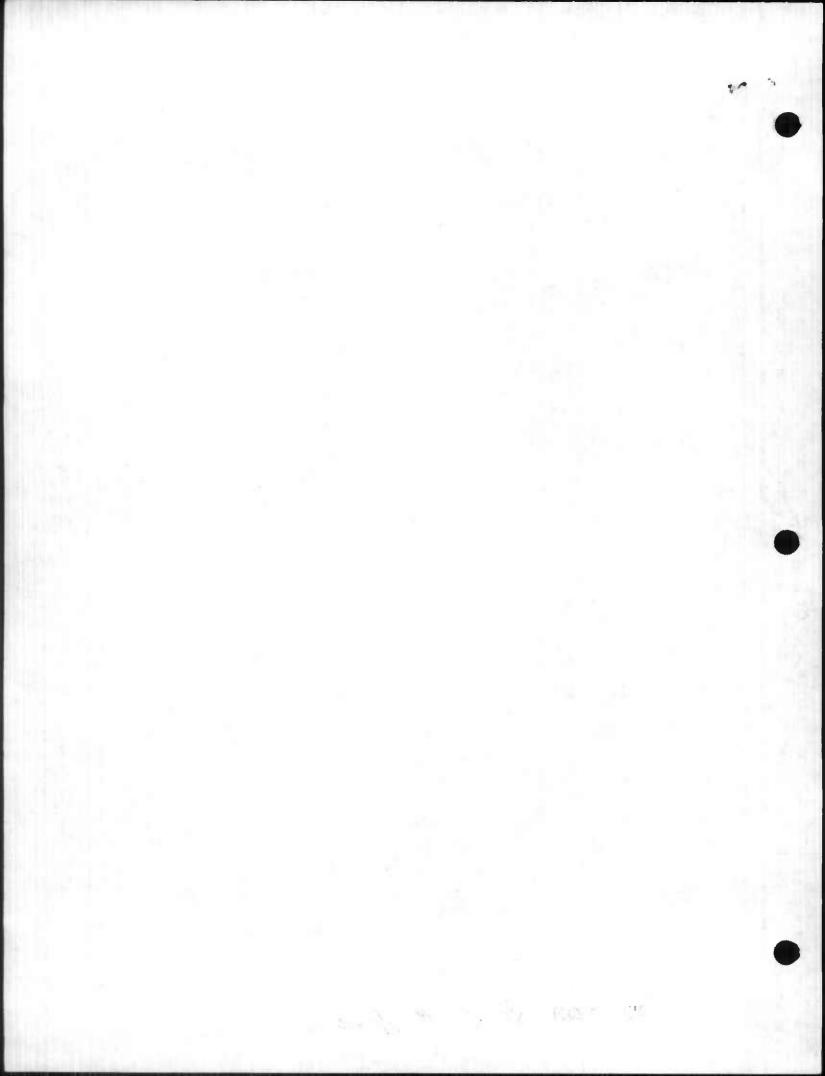


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dical niner	48	Facility Name	(If not institution		-		2102110			4b. City, Town, or				J.J. JU E.I
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al or		52-03		6. Sax	M 2□F	7. Age (In yr. 91	s. last birthday, Yrs.	Months	ar 1 Yeer Deys	If Under 24 Hrs Hours Min	(Month, De	th by, Year) B, 1908	9. Birthp Cour New	place (State or Foreign htry) York
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tor		Md.	Princ	ce G	eorge	es E	Bowie							1 Yas 2 □ No
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dala of Death Month **Physician** 2:03 AM Kabin Jermaine 04 2000 449 /Medical 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Nama (If not institution, give street and number) Examiner Baltimore If Under 24 Hrs. 8. Date University of Maryland Nedical enter If Under 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 10 M 200 F Days Hours 220-78-0656 Usual Rasidence of Decedent Yrs June 30, 1962 Director Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deportment of Health and Merital Hygieria Hygieria Deportment (I flom 27 in marked other than "nahura", or Rema 23a or 28a-f shoo any injury or other traumatic event, the Medicial Examinor must be holdfilled at 1 Yes 2 No Directo Dorchester ambrida 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 2 2161 Street Funeral Was Decedani Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Dalas: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Stalus 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Black by Specify: 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 Production Line Worker Manufacturing 17. Falhar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be Kussell 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) 5211 Morayia Road (Apt. H) 20b. Placa of Disposition (Name of cometery, crematory or other place) Dete Baltinore, MD. 21206 20c. Location - City or Town, State Russell 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from Stata reys Ceneteny V22. Name and Address of Facily 8/12/2000 Aireys, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses Henry Funeral Home P. A. 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in daath) Examiner Due to (or as a consequence of): Examiner burial-transi Sequentially list conditions, if any, leading to Immediata ceuse. Entar Underlying Cause (Diseasa or injury that initiated avants resulting in death) Last and Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical USB BS ettending signed by the et d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Mknown 1 Yes 2 No 3 Probably P 24b. Ware autopsy findings available prior to completion of ceusa of death? Completed 24a. Was an autopsy performed? hes certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was cesa referred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Inpatiant 2 R/Outpatient 3 DOA 27. Manper of Death 28d. Describe how Injury occurred 28h Time of 28e. Date of Injury (Month, Day Year) 288. Injury at Work? Natural Accident 5 Pending investigation 1 ☐ Yes 2 No 6 Could not be datarmined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

25c. License number

m 23a) (Type,

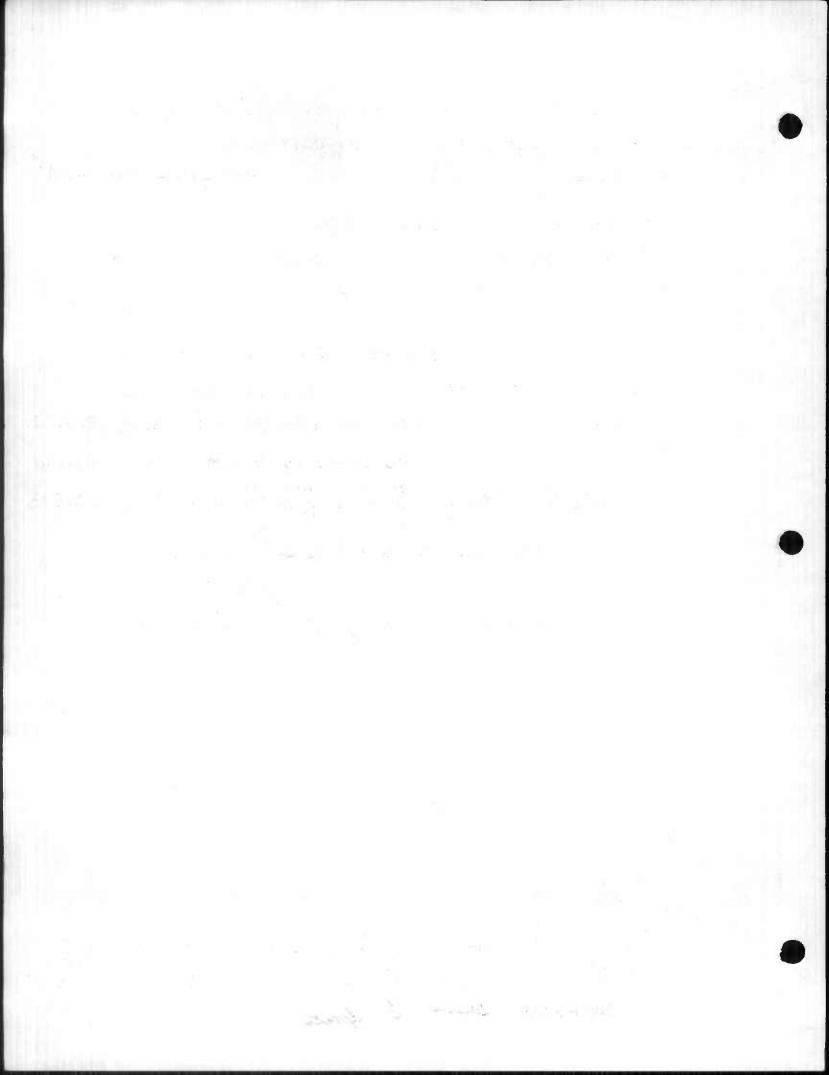
32. Registrar's Signature

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 0 9 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2, 04:30pm Rennie William Shreves Aug 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany Hours Min. 8 Dete of Birth (Month, Day, Year)
Apr 17, 1910 If Under 1 Year 5. Sociel Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Months Yrs. 214-05-5799 90 Director Usual Residence of Decedent 10a State 10b. County 10d. tnside City Limits 10c. City. Town or Location 28a-f show 1 Ves 2 □ No Allegany Directo Cumberland 10a Street and Number 10f Zin Code 10g, Citizen of What Country? ò 1 Baltimore Street 21502 USA Berrs 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify white À 3. Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Hygiene. College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien important. If flam 27 is married other than any finjury or other traumatic access. Operator Shreves Arco 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be William Harrison Shreves Dellie Teter 19e. Informent's Neme/Relationship (Type, Print)
Charles Shreves 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
9400 Steeplehill Drive; Las Vegas, NV89117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Suriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glendale Cemetery 8/08/ Flintstone, MD 21. Signature of Funeral Service Licensee Scarpeilis of Fulleral Home P.A. Cumberland, Maryland 23e. Part/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, short, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) Septic Shock caused by Aspiration /Medical 12 Hrs. Examiner Due to (or es a consequence of): Examiner Acute Renal Failure due to Dehydration 12 Hrs. Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Physician/Medical the that initieted events resulting in death) Lest Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. Senile Dementia by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? t□ Yes 2X No 1 Tyes 2 NO No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury at Work? or Attending 5 Pending Investigation 1 □ Yes 2 □ No 2 Accident Director: / 6 Could not be 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 hours after 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. edical 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) and manner/steted. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number M.D Aug 37 2000 D23334 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Shah M.D. 625 Kent Avenue Cumberland MD 21502 Dinesh 31. Date filed (Month, Pey, Year) AUG 0 4 2000 32 Registrer's Signeture State souls! Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 251, 27

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	/Medic Examin	_	4a Facility Nama (II not Institution, giva				1-11-	4b. City, To	own, or Lo	cation of Deatl	- 1			
			Calvert Memorial	Hospita.	1			Princ	e Fr	ederick	Calve	ert C	co.	
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last bir	thday)	If Undar 1 Ya	ar If Unda	r 24 Hrs. Min.	8. Data of Bir (Month, Da		9. Birtho	place (Stata or	r Foraign
	Director		577-28-3468 Usual Rasidence of Decedant	□M 2XF	80	Yrs.	MONTHS Day	ys Hours	Wiit.	Sept.	9, 1919	Wash	ningtor	1, D.C
	tar death with the Maryland terms 23a or 28a-f show her must be notified	tor	10a. Stete 10b. County MD Calvert	Co	10c. City, Town		ation					1	10d. Inside Clt 1 ☐ Yes	
	28s	Director	10e. Street and Number	co.	OW11.	igo	10f. Zip Code	9			10g. Citizan of V	Vhat Cour	itry?	
	3a o		3680 Chaneyville	Road			20736				U.S.A.			
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21215-0020	8 6	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ☐ Yaa 2 📉 If Yes, Giva Yaar or Datas:			Yas, specify C □ Yas 2💢 N			Hican, atc.)		ck, White, v: Whi		
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68	antifica ing ph a as th	8	rasulting in death) Last			7	area (1		
Вох	aath cer attendin for usa	2		d		-						1.		
	daath	Physician	Part II. Other aignificant conditions co	ntributing to death b	ut not resulting Ir	n tha und	dariving cause	givan in Part	1.	23b. Did	tobacco use co	ntribute t	o the cause of	of death?
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5	Pare Dire	ert.	4 Homicide	building, etc	c. (Specify)	MA	9			City or To	wn, State)	1		
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			30. Name and address of person who o		control by	1000			-					
			DR.STEPHEN CA 31. Date filed (Month, Day, Year)	FFERTY,	M . D .	PRI	NCE F	KEDER	ICK,	MD 2	0678			
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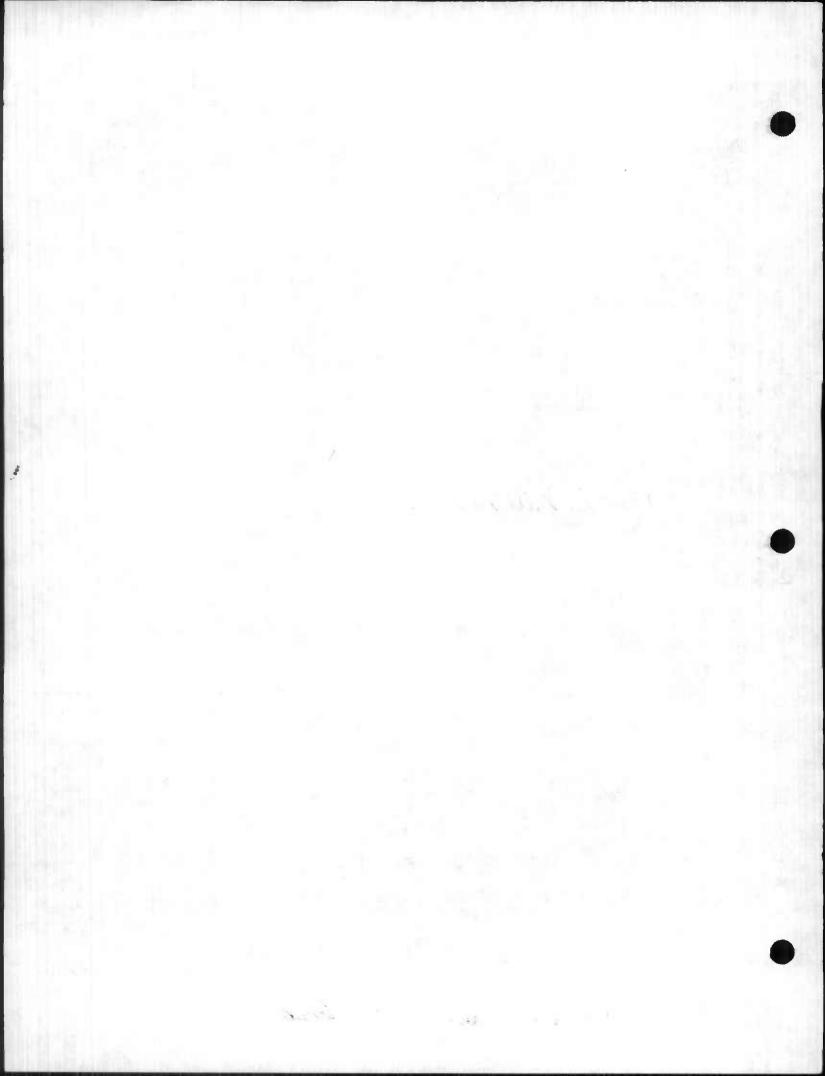
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Physiciar /Medica	1	TENT SPRIGGS TEMS: #23 PART I, 27 PER MEO Centificate of De 1. Decedent's Neme (First, Middle, Last) Sherman Spriggs, Jr.								2. Dete of De Month AUG_ cation of Deef	Dey 4, 2000								
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Funeral Director	1	212-84-6480	Sex XDM 2□F	Age (In yrs. la 36	Yrs.	Months Months	1 Yeer Deys	If Under 2 Hours	Min.	8. Dete of Bir (Month, De Sept.	year) 1963	9. Birthplace (State or Foreig Country) Maryland							
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3a or 28	5	Oa. Street and Number 806 W. Chesapea	Road	10f. Zip Code 20736					7-5-3	10g. Citizen of W	Vhsf Country?								
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Department of Heal Important: If Item 2 any injury or other BRISS.	2	20e. Method of Disposition 1																	
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Service Control of the State of Maryland / Department of Health and Mental Hygiene

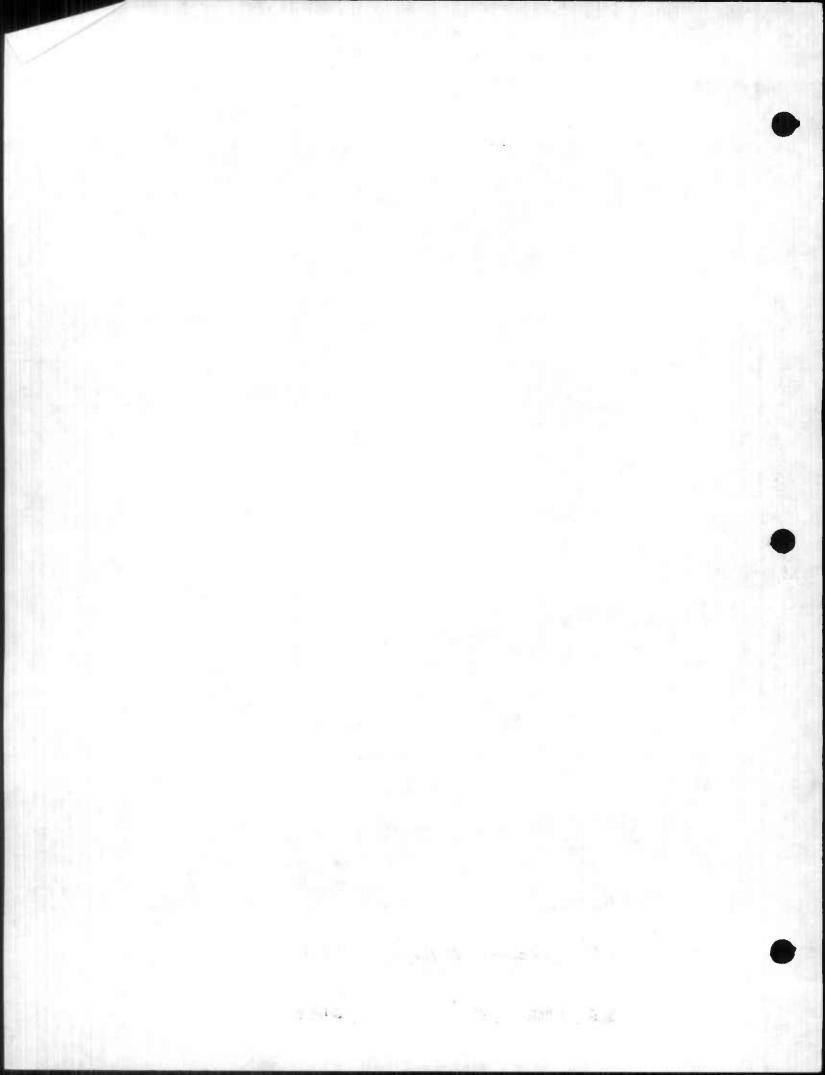
26429 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Day 8 **Physician** Charles Edward August 2000 Smith 4:05 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) Aug. 24, 1931 If Undar 1 Yaar If Under 24 Hrs. 6. Sex 12 M 2 F 5. Social Security Number 7. Age (tn yrs. lest birthday) 9. Birthplace (Stele or Foreign **Funeral** Months Deys Hours Min Yrs. Michigan 68 317-30-5107 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Directo Maryland Frederick Mount Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code marat be n 21771 U.S.A. 4298 Molesworth Terrace Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Ki Yas 2 □ No If Yes, Give Year or Dates: Kor Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Korea Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Hygiene. Security Officier Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) emit. Pages 1 and 2 should be fit operant of Health and Mental H sportant: if Nem 27 is marked off ny Injury or other treameds even Be Zenna Lindsay Walter W. Smith 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol L. Smith - Wife 4298 Molesworth Terrace, Mount Airy, Maryland 21771 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removat from State Parklawn Memorial Park 8/11/00 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furgerat Service Licenses 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home Trest 26401 Ridge Road, Damascus, Maryland 20872-0117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician immediate Cause (Final disease or condition resulting in death) /Medical 40 MIN VENTRICULAR FIBRILL ATION Examiner Due to (or as a consequence of): Physician/Medical Examiner MYOCARDIAL INFARCTION sician and burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be execu Box 68760, ARTERIOSCLEROTIC CARDIO VASCULAR thet initiated events resulting in death) Last Due to (or as a consequence of) use as the P.O. 23b. Did tobacco use contributs to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably Dunknown MELLITUS à of Vital Records, 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? After this certificate has page 1 Yes 25 No 1 Yes 2 No or Attending Physician: Be 25. Wes case referred to medicat 26. Plece of Deeth (Check only one) Hospitel: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Naturat 2 Accident after death. 1 Yes 2 No the 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Streat and Number or Rurel Routa Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, end due to the cause(s) and manner as stated

1 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier he.D. UPMA 2000 M CHOREAL 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) FLEDERICK VICE MEDICAL SHITH FREDERICE 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State AUG 0 9 2000 32 men Registrar

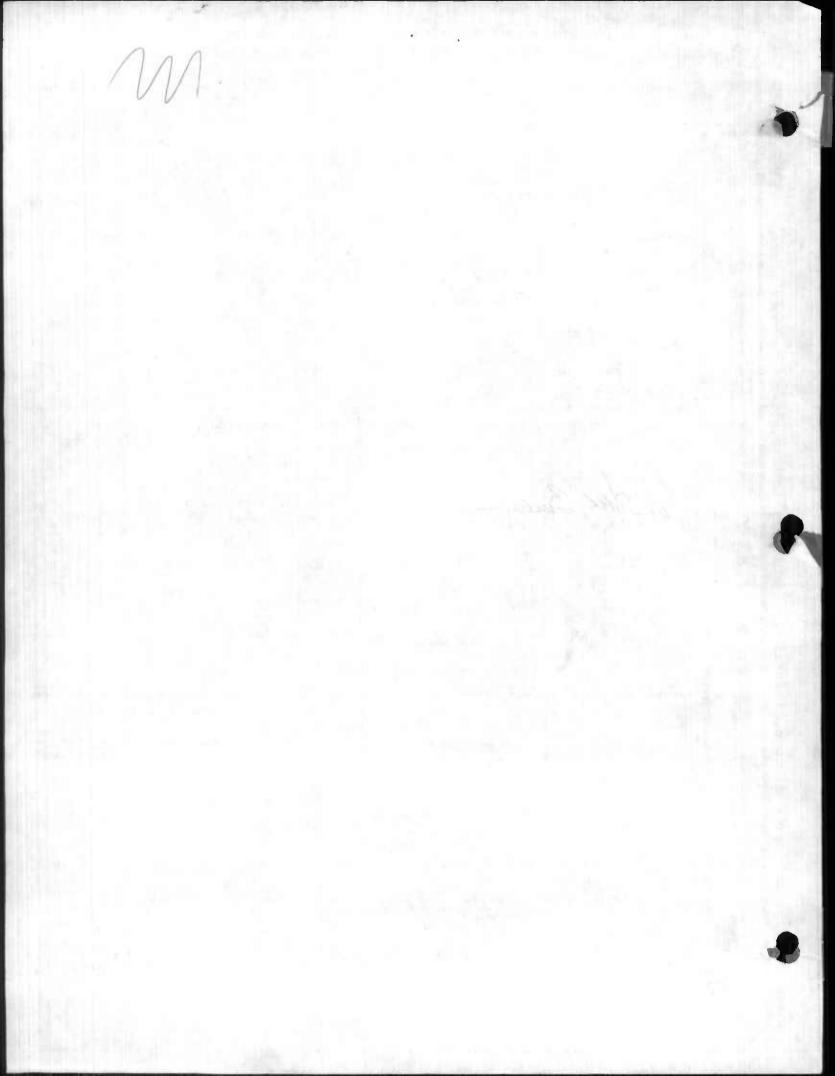


State of Maryland / Department of Health and Mental Hygiene 00 26430

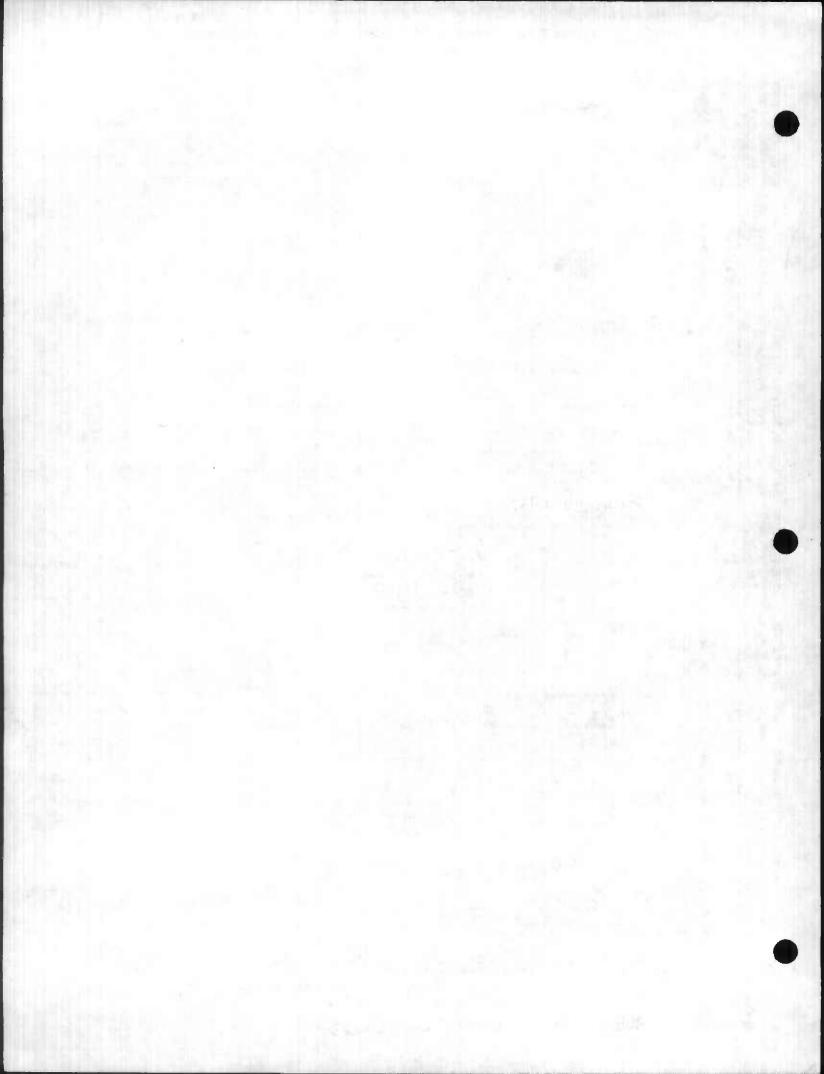
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ıneral	SHADY GROV 5. Social Security Number 061–09–6537	6. Sex	7. Age (In yrs. last		If Under 1	Year Days	If Under Hours	KVI 24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9.1		State or Foreign	
o or 28a-1 show the notified at Director	Usuat Residence of Decedent 10a. State 10b. County		10c. City, T		cation				June 1	0,191	6 Ne	W Yor	K side City Limits	
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ny or oth	20e. Method of Disposition 1 Burial 2 Cremetion 4 Donation 5 Other (3		Stete cem	etery, cren	sition (Name natory or oth Mem.	er plac		8-	Date -9-00			or Town, Si		
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should be d	Relatively Re-	cent ceret	orai illa	ret					24a. Wes	s an autops ormed?	y 24	available	on of ceuse	
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led in by the funeral Certification:	1 🖾 Naturel 5 🗌 Pendi 2 🗍 Accident invest 3 🗍 Suicide 6 🗍 Could 4 📗 Homicide detern	not be 28e. Ptec		M 1 ☐ Yes 2 ☐ No 1 Injury - At home, farm, street, factory, office 28f. Loc						Location (Street end Number or Rural Route Number, City or Town, State)				
To the Funeral Director: completely filled in by the Medical Certifical		ng Physician: To the Examiner: On the b											ause(s)	
comple	29b. Signature and title of certific		n H-/) =	29c.	Licens	e number	0		29d. Date	M) bengis	10nth, Day, 1	Vear)	
		amma / 990	Ol Medica	1 Cen		٠,	Roc	kvil.	le, MD	2085	0 -			
State Registrar	31. Date filed (Month, Day, Year, AUG 0	9 2000	Registraf W.Signature		4.	90	ares	1						



51	1. Decedent'a Name (First, Middle, L	ast)							2. Date of Dee	eth Day	Year	3. Time of Death	
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miner	4a Fscility Neme (If not institution, gi	ive street and numb	er)						cation of Death		ty of Death		
	30 Leslie Muse 5. Social Security Number 6.	Sex 7.	Age (In yrs. las	st hirthday)	If Under 1 Ye		Cear				ceste		
ral tor	088-20-6501	1 ⊠ M 2□F	74	Yrs.	Months De		ours	Min.	6. Dete of Birth (Month, De) 5/7/1	926	Coul	placa (State or Foreign ntry) PA	
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tor	MD Word	ester	(Ocean	Pines							Yes 2□No	
Director	10e. Street and Number		1		10f. Zip Cod	ie				10g. Citizen of	What Cou	ntry?	
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	19a. Informent's Neme/Ralationship Marilyn Stefan								Pines		21811	D C00e)	
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	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Space	Removal from State)	916				nato	ry	7/31/00	Fran	kford	I, DE	
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al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einer Underlying	· 1/166	turns	is a conseque								Onset and Death	
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edicai C	29a. Certifier (Check only one) Certifying Pi	hysician: To)the be	s of axamination	edga, deeth on and/or inve	occurred et the stigetion, in m	e time, da ny opinion	ata and n, deeth	place,	and dua to the ded et the time, d	cause(s) and n	nannar as s , and due t	stated. to the cause(s)	
Me	29b. Signeture and title of continer	1/1/	1 July	As.	29c. Lic	ense nur	mber			29d. Date sign	ed (Month,	, Day, Year)	
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	CRISNIT; MD DSO 255 7/30/2 30. Name and address of person who campleted cause of death (Itam 23a) (Type, Print) 9733												



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0	or he		1 Nevar Married 2 Married	Armed For 1 X Yes If Yes, Give			Link				rican, etc.)		ack, White			
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ē,	permit. Pages 1 and 2 should by Departit end of Health and Menta Important: If Hem 27 is marked any injury or other traumatic and bods.	1	Darlene Smith / D 20a. Mathod of Disposition	augnter	20b.	Place of Disposemetery, on	osition (N	ame of		1	Date	20c. Location		own, Stata		
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Baitimore,	mit.	1	21. Signature of Funaral Sarvice Licer	500	101				ss of Facili	ty					Ī	
m	Deparition any ir	B	Lisa M. Scott Funeral Services 552 Lewis Street, Havre de Grace, MD 21078													
		10	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the dea	th. Do not e	nter the mo	ode of dyin	ng, such es	cardiac	or respiratory a	rrest,	ace,	Approximate Interval Between		
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48	/Medical Examiner	7												LWES.		
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Vitai	Physician: The law this certificate has rel director, page 2	(C)	25. Wes case referred to medical axaminar?	Hospital:	/			104	26. Place	e of Deal	th (Check only	one)				
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	To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by	edical	(Check only 2 Medical Exam	niner: On the ba and mann		erion and/of				ain occur	red et the time,					
	To t To th		29b. Signature and title of certifier	11/	4		2	9c. Licens	sa number			29d. Date sig	ned (Month	n, Day, Year)		
			1/10/11	Mari	18		4	040	092	Z		7/5/	2000	7,		
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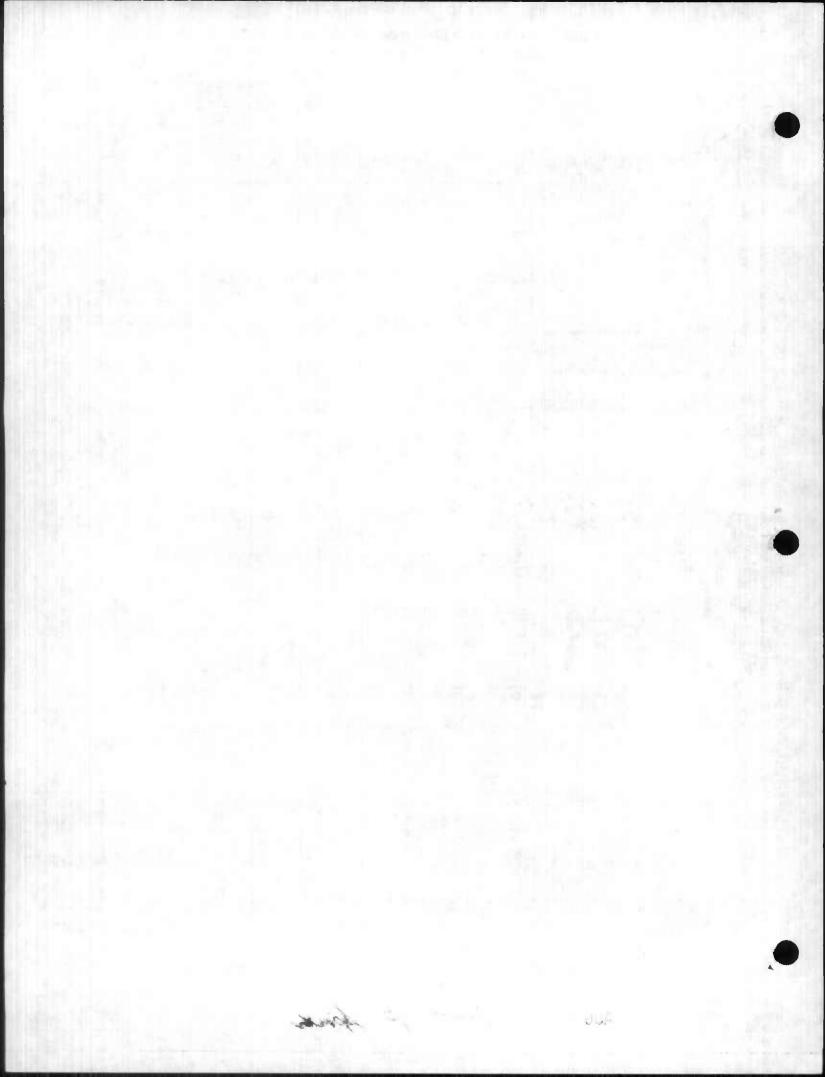
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State of Maryland / Department of Health and Mental Hygiene

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ical ner	4a Facility Name (If not institution,					4b. City, Town,	or Location of Dea	•		
	CALVERT MEMOR		ral				FREDERIC		VERT	
	5. Social Security Number 385 38 9789	1 1 M 2 2 E	(In yrs. last birt		nder 1 Year oths Days		lin. (Month, D			e (State or Fo
	Usuai Residence of Decedent		57				OCTOBER	8 9, 1942	MICHI	GAIN
	10a. State 10b. County		10c. City, Town						10d.	Inside City L
ector	MARYLAND CALVE	SRT	LUSBY							1 Yes 2
늄	10e. Street and Number 12237 CONCHO COUF	RT.			1. Zip Code 20657			10g. Citizen of UNITED		
Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. Was D	ecedent of I	dispanic Origin	(Specify Yes or Nuerto Rican, etc.)	o- 14. Rac	ce - American ck, White, etc	
by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced		0		es 2 No	Specify:	30110 1 110411, 010.,	Specif		
	15, Decedent's	Education	16a.	Decedent's	Usual Occu	pation	dela-a	16b. Kind of B	usiness/Indus	itry
Completed	(Specify only highest (Elementary/Secondary (0-12)	grade completed) College (1-4or 54	·)	life. DO No	of work done OT use retire	during most of d)	working			
Con	12		MA	NAGER					SERVICE	2
Be	17. Father's Name (First, Middle, La ARNOLD RAY COATS						Name (First, Middl ORIS GREG		n <i>e)</i>	
10	19a. Informant's Name/Relationship		19h	Meiling Ade	iress (Street		Rural Route Num		, Stete, Zio Co	ode)
	VICKY M. POLECK						LUSBY, MA			
	20a. Method of Disposition	Damavel from State		y, crematory	or other pla		Date	20c. Location		
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	21. Signature of Funeral Service Lic	censee	01	22. Nan	e and Addre	ess of Facility	RAUSCH FU	NERAL HO	DME, P.	A.
	Mailes ;	7. 1300	1	4405	BROOM	ES ISLA	ND ROAD,	PORT RE	PUBLIC	, MD
Examiner	Sequentially list conditions,	b	Oue to (or as a c						1	
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n/Medical	that initiated events resulting in death) Last	_ d	oue to (or as a c	onsequence	of):				1	
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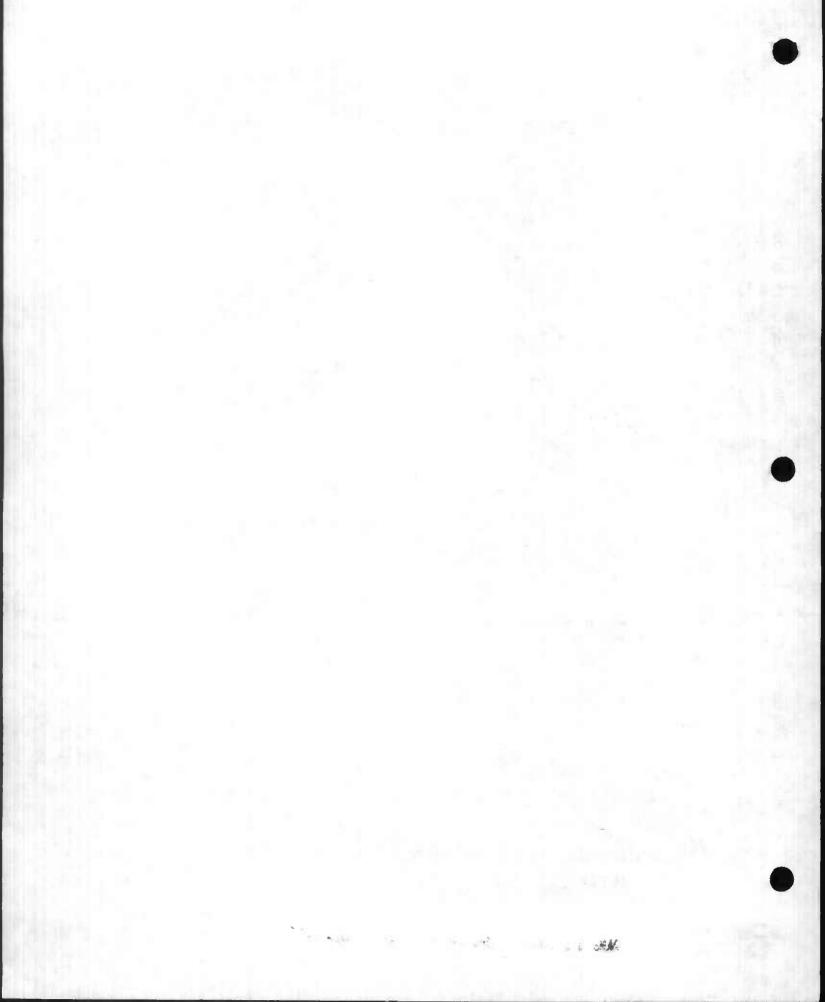
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State of Maryland / Department of Health and Mental Hygiene 26434 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Charles Anthony Wood August
4b. City, Town, or Location of Death , 2000 8:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Hunder 24 Hrs. 8. Date of Birth (Month, Dey, Xear) If Under 1 Year 9. Birthplace (State or Foreign 1945 Alabama 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days 422-56-3539 55 Yrs. Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Frederick Maryland Walkersville Director 10f. Zip Code 10g. Citizen of What Country? 8796 Victory Court 21793 8 United States Herrie 23a Funeral 12. Was Decedent Evar in U.S. Armed Forces?

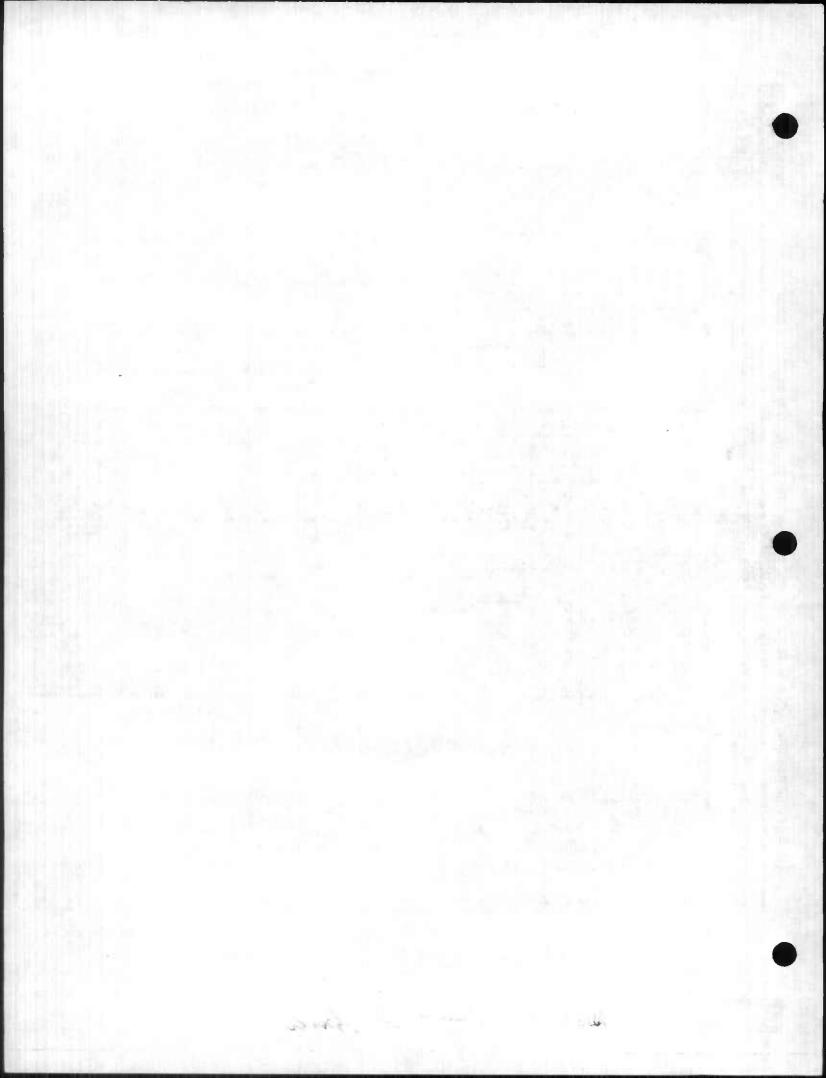
120 Yes 2 D.No. 77 P. If Yes, Give 1.990 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Manial Stalus Specify White 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Radiation Waste Manager U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be mant of Health and Mental ant: If hem 27 is marked o Charles William Wood Louise Talley Miller pus si 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Angela Wood /Wife 8796 Victory Ct. Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Department of Important: If It any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐,Other (Specify) Resthaven Crematory 8/2/00 Frederick, MD 22 Name and Address of Facility Licensee Skkot Cody 21. Signature gl.Pungfal Service Licenses 604 Admiral Dr. #451 Annapolis, MD 21401 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximale Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) lamponade Examiner Due to (or as a consequence of) Examine Small The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pus Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ ¥6s 2 □ No 3 □ Probably 4 □ Unknown of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Be Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese reterred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After Division Injury 5 Pending Investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Hospital 1[Dertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MTolino 8-2-00 an (M. Tolino) MD 51610 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Frederick Suite AUR 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 03 LUUL Registrar



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				State of M	larylar				lealth a	and Mental		ene 0	2	643	35
			1. Decedent's Name (First, Middle, La	ist)						2. Data	of Death			3. Tima o	Death
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			CHARLES W. BENNET 31. Data filed (Month, Day, Year)				TRUE	MAN I	ROAD,	LUSBY, N	IARY	LAND 20	0657		
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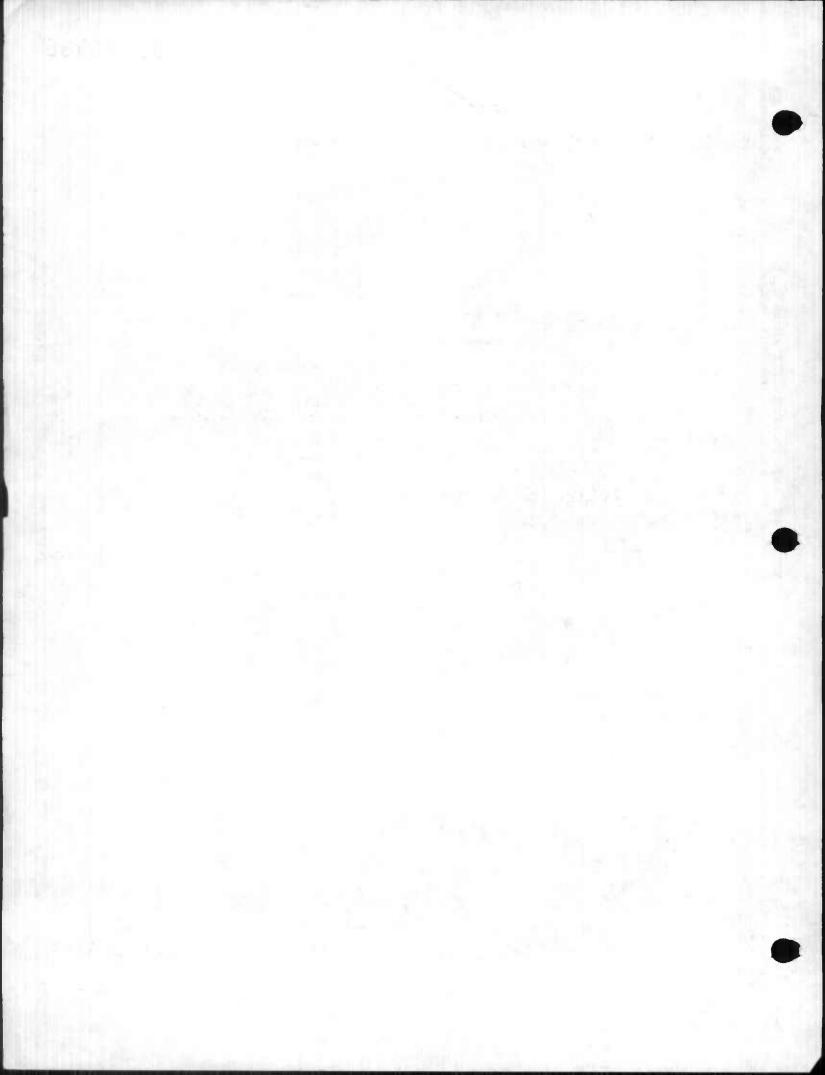
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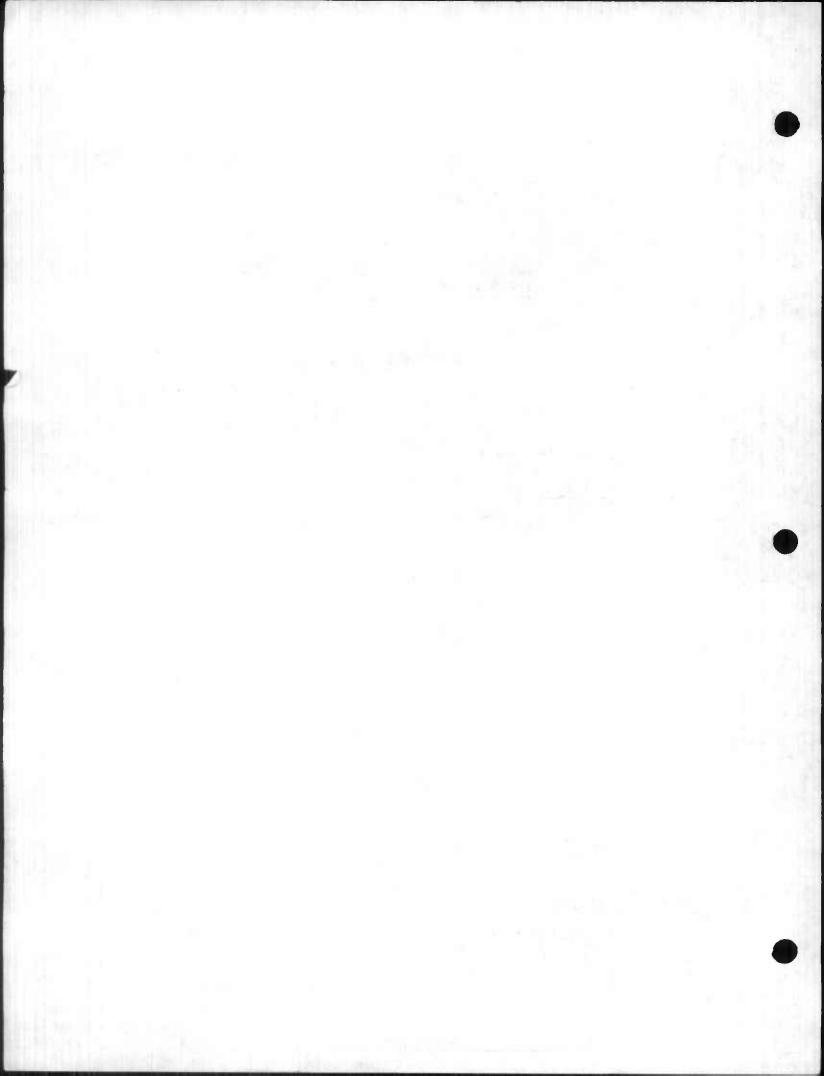
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State of Maryland / Department of Health and Mental Hygiene 00 26436

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. Committee	1008 Poplar Hi	11 Road				Baltir	mre		N	I/A	
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	Mrs Christine B	. Armor (W	ife)	1008	Poplar	Hill	Road	d, Balti	imore, M	Maryla	and 2121
	20e. Method of Disposition		com	e of Disposition	on (Neme of	ace)		Date	20c. Location	- City or To	wn, State
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26438 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:56 PM 2000 august JOSEPH M ALPERT 17 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Baltimore Hospital DINGI If Undar 24 Hrs. 8. Date of Birth Hours Min. SEPT 20. 1916 If Undar 1 Year 5. Social Security Number 7. Aga (fn yrs. last birthday) 9. Birthplace (State or Foraign **Funeral** XXM 2DF Months Days NEW HAVEN, CT. 83 Yrs. Director 213-14-2447 Usual Rasidance of Decedant the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow fram 27 to marked other than "natural", or frama 23a or 28a-f abov other traumatic avant, the Madical Examiner must be notified at MD 15 Yes 2 □ No N/A BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7218 PARK HEIGHTS AVE. APT.308 21208 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Nevar Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify. SpecifWHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry Collega (1-4or 5+) COMMERCIAL ARTIST Elementary/Secondary (0-12) Hygiena. ADVERTISING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 12 should be fi and Mental F 1e marked of MAX ALPERT ENNIE SHERMAN Pages 1 and 2 should nent of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Health I MRS.TRUDE ALPERT/WIFE 7218 PARK HEIGHTS AVE. APT.308 BALTIMORE, MD. 21208 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State permit. Pages Department of Important: if it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 8/20/00 REISTERSTOWN, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS. INC.) whent 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsal and Death **Physician** Immediate Cause (Finet disease or condition resulting in deeth) /Medical ardiogenic Examiner Due to (or as e consequence of) Physician/Medical Examiner MNO requires that the death certificate be executed signed by the attending physician and die detached for use as the bunal-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Dua to (or es a consequence of): Dua to (or as a consequence of) Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown p Division of Vital Records. 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? pege 2 should Completed Tha law has ils certificate h 2 X No 1 ☐ Yes 2 ☐ No 1 Yes Physicien: 25. Was case referred to medical axaminer? 89 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of tnjury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation or Attending 1 Natural 2 Accident of Director: An 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

within 24 hours a
To the Funeral C To the Hospital edical State Registrar

Joseph

Alpert,

CRISLER 2000

29a. Certifier

(Check only one)

29b. Signature and little of certifier

0.0. 32. Registrar's Signature

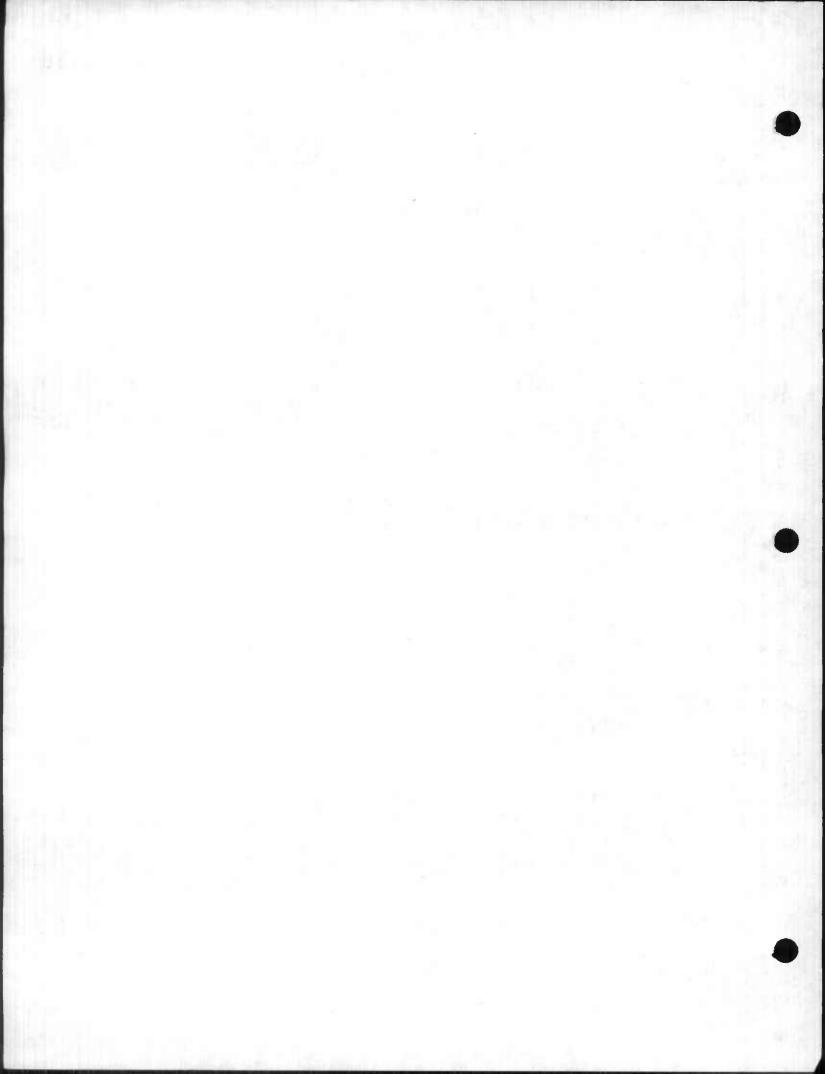
30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

2401 W. Selvedore ave Baltimore MD Hospital

29c. Licansa number

29d. Date signed (Month, Day, Year)

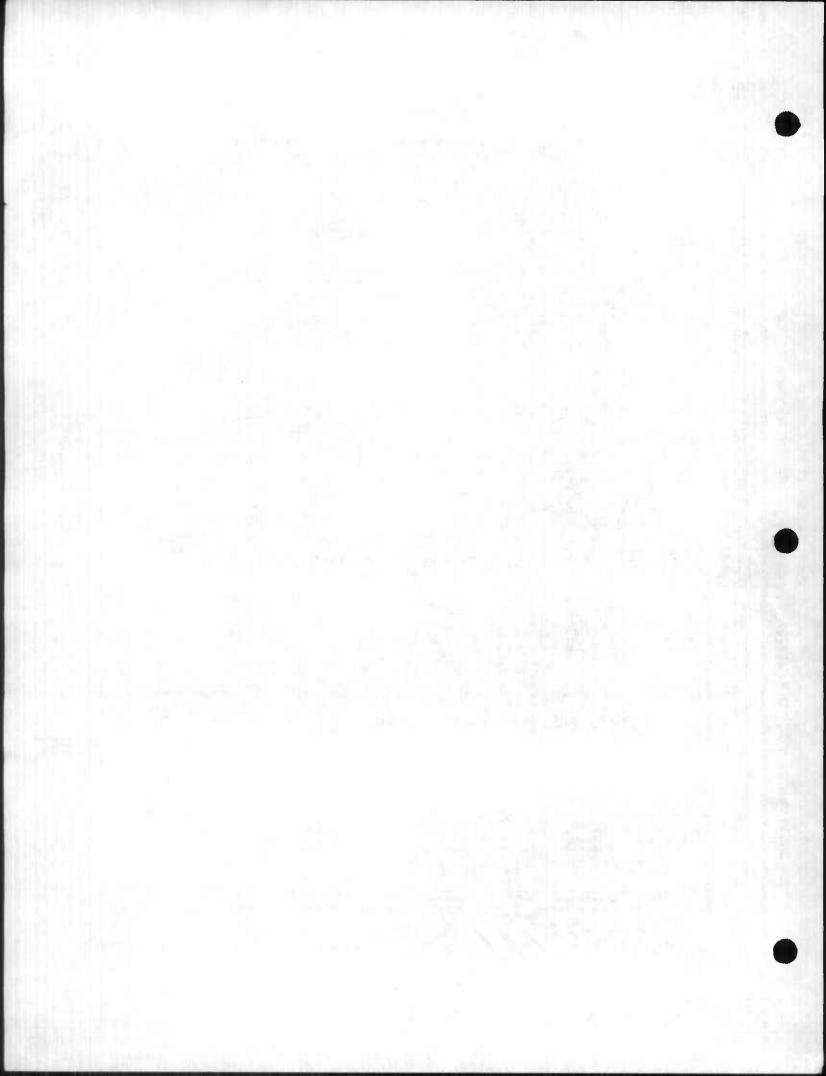
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State of Maryland / Department of Health and Mental Hygiene 00 26439

			Cer	tificate d	of Death	F	leg. No.	/ S.m	0403
	1. Decedent's Name (First, Middle, Las	51)				2. Date of Dea Month	ith Day	Yaar	3. Time of Death
Physician /Medical	Hattie	A	s Ken yland			08		000	1708
Examiner	4a Facility Nama (If not Institution, give	street and number)	0 1		4b. City, Town, or	Location of Death	4c. County of	of Death	
	Universit	y of Mai	ryland		1 00001	rove	Balli	mere	e City
Funeral Director	5. Social Security Number 6. S 264-40-0036	9x 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Y	ear If Under 24 Hrs lys Hours Min		8 1920	9. Birthpla Country G	ca (State or Porei y) A
2	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Loc	nation				10	d. Inside City Limi
aho state	MD ANNE ARI		EN BUR					100	1 ☐ Yes 2 ☑ h
be notified Director		ONDER GE	EN DOR	7					41
	10e. Street and Number 424 LINCOLN DI	RIVE		10f. Zlp Cod 21	060		US A		y7
inf. or itsms 23 Examiner must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ll ll	Yas, specify (of Hispanic Origin? (s Cuban, Maxicen, Pue No Specify:	Specify Yas or No- rto Rican, etc.)		e - Amaricae k, Whita, at BLA	ic.
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and Ide	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use re	tired)				
Co Co	10th	NA	HOU	SEWIF			AT HOM		
B son	17. Father's Name (First, Middle, Last) EUGENE DINKIN	J.S				me (First, Middle, R DINKI		a)	
2 2 2 P									
During and	19a. Informant's Name/Relationship (1) JOSEPH ASKEW -			-	reet and Number or R		_		
Dar t					LN DRIVE				21060
ant: If the ury or off	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Stata	Place of Dispos cemetery, crem VERGRE	atory or othar	place)	8-21-00	JACKSO		
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-	23a Part Enter the disease, or companies or heard tailure. List only	plications that caused the de						: /	Approximate Interval Between
hysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	-	(or as a consequ		rysm			1	
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as after death. al Diractor: After to led in by the funer. Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spe	home, farm, stre	et, factory, of	lice	281. Location (S City or Tox	Street and Number, State)	er or Rural	Routa Number,
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within 2 To the comple	29b. Signature and Httl of certifies	/ / /		29c. Li	cense number		29d. Date signed	Month, E	Pay, Year)
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	1/100	none			(1.10412212		- 1	. 4 1 - 6	
1	30. Name and address of person who	completed cause of death (It	em 23a) (Type, I	Print)	1011.	- 11	/ /		
	NIRAV Shish	,22 South	Greene	Thee	+ BAHTINOV	19 MARY	And 218	701	
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	pature						
Registrar	LILLY / / / IIII	/ Indiana	111111	H Alah					



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#* PERFHG787 9/8/2000 EW Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Death 10:50 An **Physician** 2000 20 Aug Hichard Becker /Medical 4b. City, Town, or Location of Deeth 48 Facility Name (Margi Institution, give street and number)
Series Stevens HKW 1 4c. County of Death Examiner 21234 Bauto country If Under 1 Year If Under 24 Hrs. 8. Dete of Birth 8-17-29 9. Birthplaca (Stete or Foraign (Month, Dey, Year)
August 13,1929 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1⊠M 2□ F Maryland Yrs. Director 214-26-8288 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore City 1 XYes 2 □ No N/A Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? b 23s U.S.A. 21214 6029 Old Harford Rd. Funeral 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 21215-0020 White 1 ☐ Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Cloverland Dairy 8yr's Laborer Maryland 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Pages 1 and 2 should be fill mant of Health and Mental H lant: If Rem 27 is marked off 88 Hochrein Chenowith Becker Katherine Richard 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 301 Halsey Road Annapolis, Maryland 21401 nt of Health a If Item 27 is or other tra John N. Ruth - Attorney Baltimore, 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Data Parkwood Cemetery 1 Burlei 2 Cremetion 3 Removel from Stele 8-23-00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funeral Service Ligensee Baltimore, Maryland 21214 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feilure. List only one ceusa on each lina. Inc. 5305 Harford Rd. **Physician** Cerebrorescula Diser /Medical Immediate Causa (Finel disease or condition resulting in death) Examiner Examiner The lew requires that the deeth certificate be asscuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): signed by the a Partil. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. Completed by 24b. Wera autopsy tindings evailable prior to completion of causa of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 3 Ne certificate 25. Was case referred to medial examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 M6 this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of tnjury 28d. Describe how injury occurred 28c. Injury at Work? After Division Attanding 1 Neturel 5 Pending investigation i after death.

I Director: After the further the furt 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide ŏ To the Hospital within 24 hours a To the Funeral D 29e. Certifier 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

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29d. Date signed (Month, Dey, Year)

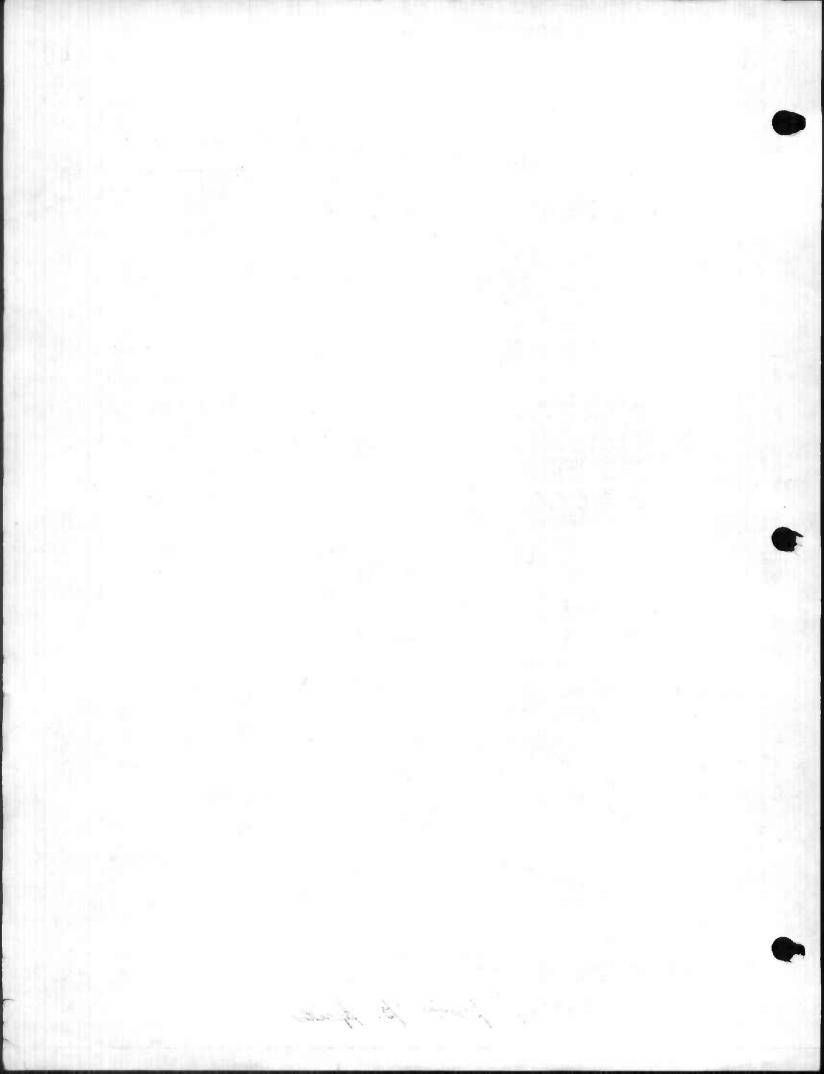
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

(Check only onel

29b. Signature and title of certifier.

2 2000

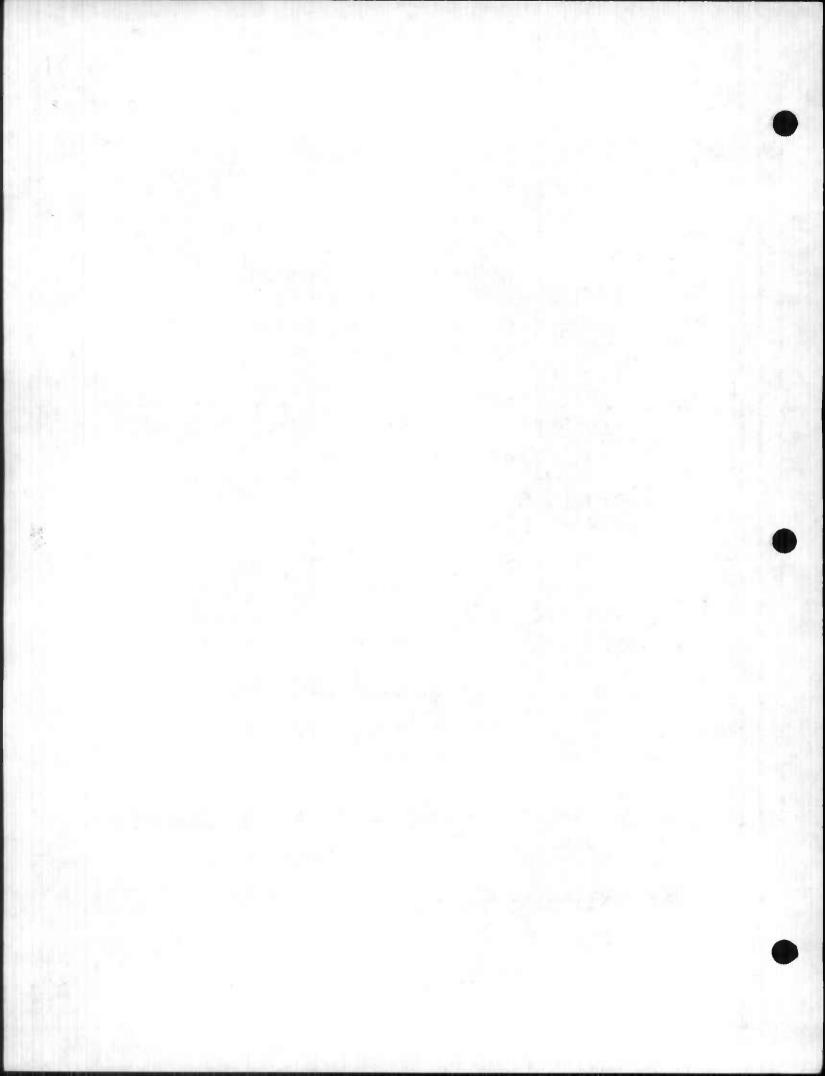


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State of Maryland / Department of Health and Mental Hygiene

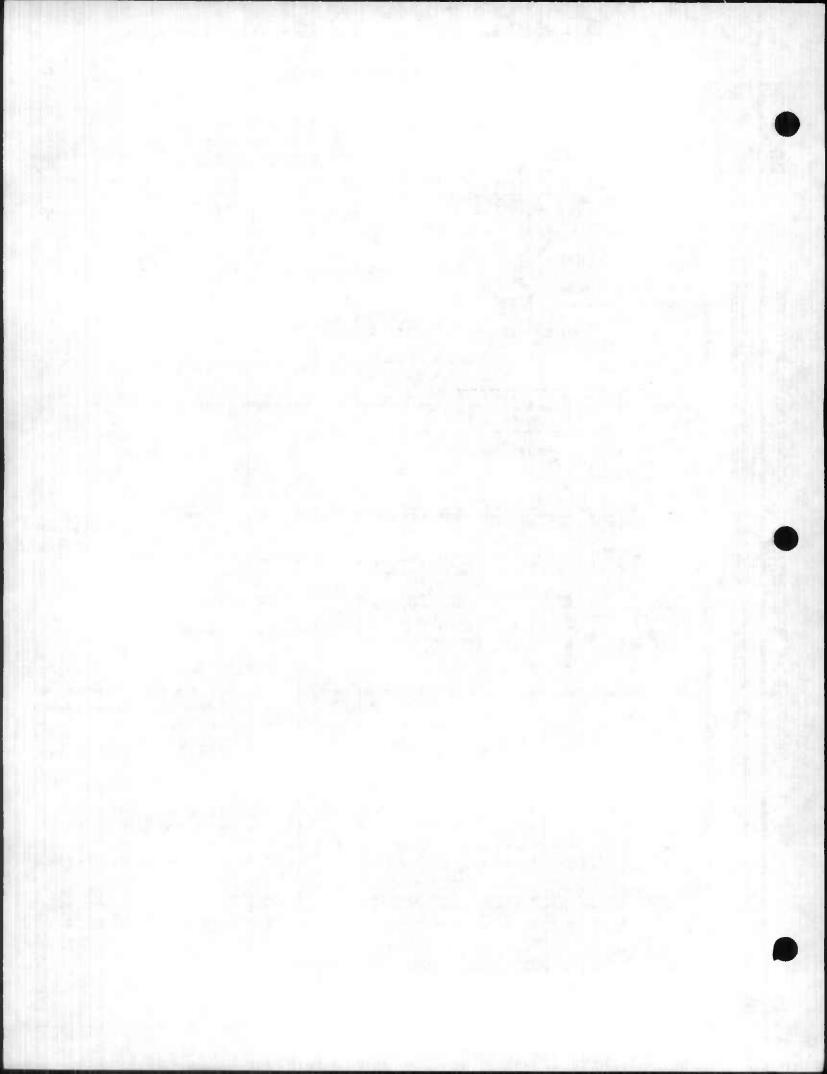
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VW	AMEND I	TEM: # 17 PER	F.H. G786	8-22-	O Certifica	ate of	Death	mornar rry	Reg. No.	0 2	26442
		1. Decedent's Name (First, Midd		SER LON				2. Date of De	ath	Year	3. Time of Death
-8	Physician /Medical	Evelyn Boyer						AUGUS	T 20,200	00	02:05 A.M.
	Examiner	4a Facility Name (If not institution			3/4		4b. City, Town, or				
		6150 FORELAN				1 - 1 \(\frac{1}{2} \)	COLUM			VARD	
	Funeral Director	5. Social Security Number 212–30–8017 Usual Residence of Decedent	6. Sex 1 □ M 2 F	Age (In yrs. last	Yrs. If Un Monti	der 1 Yeer ns Days	If Under 24 Hrs Hours Min		th by, Year) 1916	9. Birthp	place (State or Foreign ntry) Unknown
	with the Maryland a or 28e4 show be notified at Director	10a, Stete 10b. County	y	10c. City, To	own or Location	6				1	10d. Inside City Limits 1 ☐ Yes 2 No
	or 28e-f s be notified Director	MD Howar	d	Colum		Zip Code			10g. Citizen of V	What Cour	
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Balt	Departition of the control of the co	21. Signature of Funeral Segrice	Calle L			-	ss of Facility Ashton-So				Inc. land 21228
	HILL T	23a. Part1. Enter the disease, or shock, or heart feilure. Lis	r complications that only	sed the death. E						-	Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· D ron	Due to (or es	/SSSO	인 AT	on with	_ ATH		notic	Onset end Death
	axecuted in and ial-transit		b. C/Sou				176026				
68760,	ificate be asscuted gphysician and as the buful-transit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с		a consequence						
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	death car a attendir ad for use	Pert II. Other significant conditi	ons contributing to death	but not resultin	ig in the underlyin	g cause gi	ven in Part I.	23b. Did	tobacco uee co	ntribute t	to the cause of death?
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Ä	certificate has rector, page 2 be Comp							10	√es 2□No	11	DYes 2□ No
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_	To the Hospital or Attending Phone 24 hours after death. To the Funeral Director. After the complataly filled in by the funeral Medical Certification:	(Check only 21) Medica	ng Physician: To the best Examiner: On the basis	st of my knowled of examination				e, and due to the	cause(s) and m	anner as s	
	Med Med	one) 29b. Signature end title of certific	and menner	stated.		29c. Licen	se number		29d. Date signe	d (Month	Dev. Year)
	28	Meyrice	Melh	ll	um		C.M.E.				2000
	04	30 Name and eddress of person	D.10	CORELL	111 P	enn S	street, E	altimore	e, Maryl	and 2	21201
	State Registrar	31. Date filed (Month, Day, Year AUG		strar's Signature	B	do.	nk				

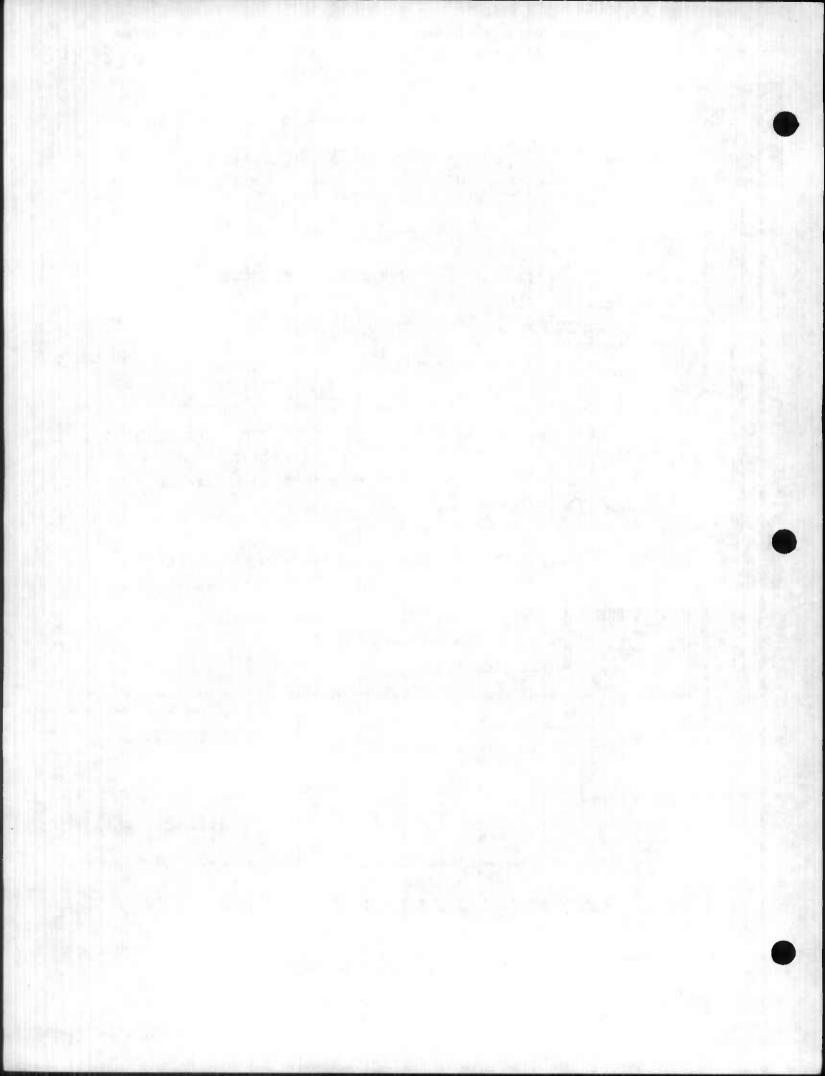


mnmr Charles E. Beckles

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na /	Department of He	aith and	mental	Hygiene	
	Cartificate of D	onth			

		1 Decedent's	Name (First, Middle, L	act)		Cei	tificat	e of	Death	2. Date of De	Reg. No.			ima of Death
	Physician		les Edward		Jr.							, 200		1815 pm
	/Medical Examiner	4e Facility Ne	eme (If not institution, g Secour Hos	ive street and nun		+ 4			4b. City, Town, or I Baltimo	Location of Deal	lh 4c.	County of D		L
	Funeral Director	5. Social Section 214–58		Sex 1 Do M 2□ F	7. Age (In yrs 47	. last birthday) Yrs.	If Under Months	1 Yeer Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, D			Birthplace (S Country)	State or Foreign
Pu		Usual Reside	nce of Decedent 10b, County		10c C	ity, Town or Lo	cation							side City Limits
Maryle	1 sho		n/a	a	100.0		altin	nore					1	Xes 2□No
death with the Maryland	r items 23a or 28a-f shown for must be notified at Funeral Director	10a. Streel ar 1702	N. Fulton A	venue			10f. Zip		217		10g. Citiz	usa USA	t Country?	
21215-0020 d within 72 hours after deat	Fune	11. Marital St. 1 Never	atus r Married 2 Married wed 4 Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv. Year or Da	rces? 2 No		Was Deced f Yes, spec		Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		Black, V	American Ind White, etc. Black	ien,
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Baltimore,	ortani Injury		ation 5 ☐ Other (Spec						ess of Facility Nu					
Balt parmit.	eny f	1 blu	not R	Chin	%				ns Falls					
100		23a. Part1. E	inter the disease, or coor heart failure. List onl	mplications that of	served they doe							ore,		oximate val Between
//	ysician Medical caminer	fmmediate Codisease or corresulting in de	ondition	· Ja		or as a consec		CF	avoion	scus	n Di	respe		
68760, fficate be execute	physician and street the burial-transit	Sequentially if any, leading ceuse. Enter	list conditions, g to immediate 'Underlying ase or injury events	0.	Due to (or as a consec	uence of):							
	0 4	resulting in de	events eath) Last	c	Due to (or es e conseq	uence of):							
. 5	the atta thed for ysicia	Part II. Other	significant conditions	contributing to de	ath but not re	sulting in the u	nderlying c	euse gi	ven in Part I.	23b. Dfc	tobacco	use contri	bute to the c	cause of death?
S, P.O	signed by the attending of be detached for use a diby Physician/M									10	Yee 2	□ No 3	Probably	4 Denknown
Records,	shoul ete										s an autop lormed?	osy 2	available	on of cause
R :										10	1 2 S	□ No	† Yes	2□ No
of Vital	rector in Be	25. Was case examiner: 1\(\(\D\)\(\text{Yes}\)		Hospital:		I ma to		Otl	26. Place of De					
Of Phys	h. After this of funeral dire tlon: To	27. Manner of	Death	28a. Date o	of Injury	ER/Outpatier 28b. Time of		28c. Inju Wo	4 Li Nursing F	lome 5 ☐ Res 28d. Describe			Specify)	
Vision	ath. r: Afte ne fun atlo	1 Natur 2 Accid	lent investigati	on	h, Day Year)	Injury	М		Yes 2 No	1500				
Division at or Attending	rs after death. al Director: After t led in by the funers Certification:	3 Suici		d 288. Place	of Injury - At I	nome, farm, str ify)	eet, factor	y, office		281. Location City or To	(Street an own, State		or Rural Roul	e Number,
To the Hospital	in 24 hound in 24 hound in Funer pletely fill edical	29a. Certifier (Check or one)			sis of examin				me, date and place opinion, death occu					ause(s)
Tota	T S S S	29b. Signetar	e and title of certifier	1	81	0	290		se number				Month, Day, 1	
	00)		leypite	mel	Shel	lun	4	0.0	C.M.E.		A	ugust	20, 2	000
(Mrs.	30. Name and	address of person who	1100 -				st	reet, Bal	timore.	Mar	yland	21201	N. E.
	State	31. Date filed	(Month, Day, Year)		egistrar's Sign		la	a V						

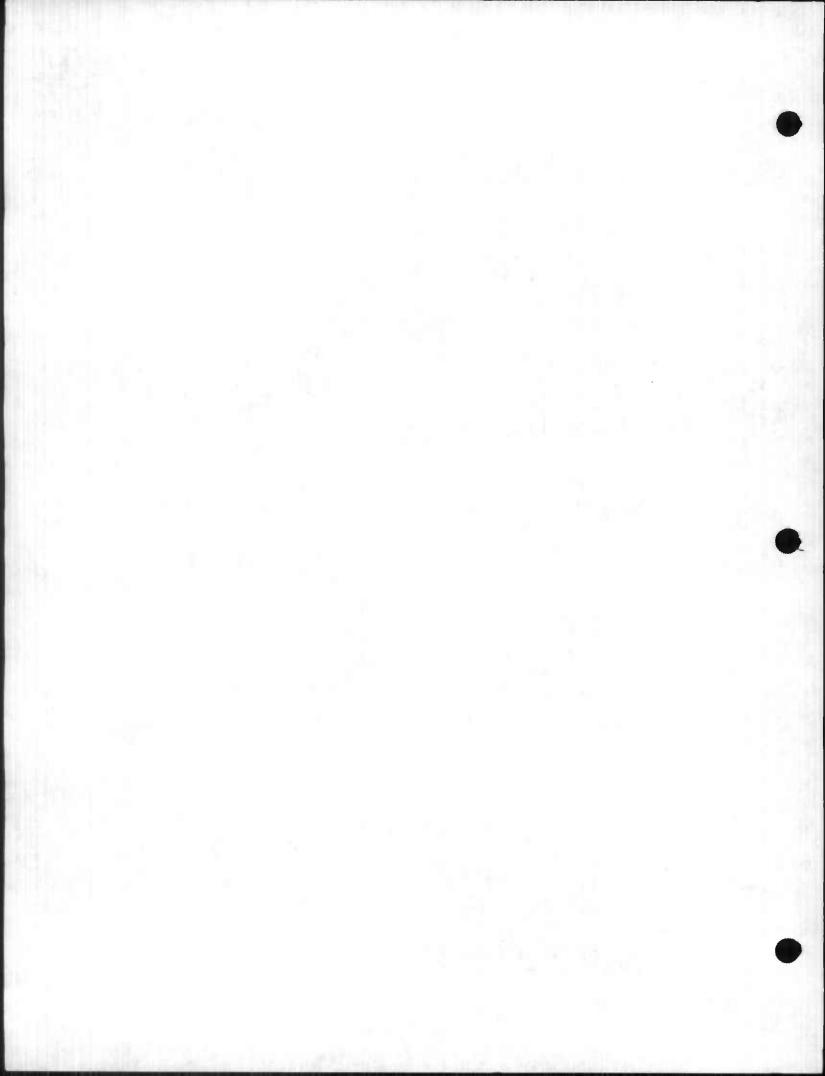


00-4603-510 mnmr Viola Brown

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State of Maryland / Department of Health and Mental Hygiene

				Certificate of Death	Reg. No.	1 26444
	Physici	an	1. Decedent's Neme (First, Middle, Last)		2. Date of Death Month Day	3. Tima of Death Year
4	/Medic		VIDIA Brown	4b. City, Town, or	August 15, 20	
	Examir	ier	4a Facility Name (If not institution, give street and number) 2115 Clifton Avenue	Baltimon	ce N/A	of Death ~
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. In Social Residence of Decedent	ast birthdey) Yrs. If Under 1 Year I Under 24 Hrs. Months Days Hours Min.	Sept. 2, 1949	9. Birthplace (State or Foreign Country) Nary and
	yland			, Town or Location	1000	10d. Inside City Limits
	e Mar	Director	Maryland NIA t	Saltimore		1∭Yes 2□No
	filed within 72 hours after death with the Maryland Hygiene. dher than "natural", or flems 23a or 28e1 show ent, the Medical Example must be incured		2115 Clifton Ave	101. Zip Code 2/2/7	10g. Citizen of W	hat Country?
	er de	Funeral	11. Maritel Status 12. Was Decedent Evar in U, Armed Forces?	 13. Was Dacedant of Hispanic Origin? (S If Yas, specify Cuban, Mexican, Puart 		- American Indien, c, Whila, alc.
21215-0020	"natural", or	by	1 Never Merried 2 Married 1 Yas 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:	Specify:	Black
15-	in 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b. Kind of Bus	siness/Industry
	2 should be filed within and Mental Hygiene. Is marked other than surnatic event, the Market and	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Candy Make	r Rheb	Candy Co.
pue	be file d oth	Be	17. Father's Name (First, Middle, Last)	/ 18. Mother's Ner	ne (First, Middle, Maiden Sumame	
Maryland	d 2 should be th and Mental 7 Is marked o traumatic eve	To	19a. Informant's Name/Relationship (Type, Print) (50n)	19b. Malling Address (Street and Number or Ru	Iral Route Number, City or Town, S	NES State, Zip Code)
			Mr. William Fossett	2115 Clifton A	ve. Balto,	Md. 21217
Baltimore,	20 0		20e. Method of Disposition 20b. Pl	lece of Disposition (Neme of amatery, cremetory or other place)	Data 20c. Location - 0	City or Town, Steta
tim	Part:		4 □ Donetion 5 □ Other (Specify)	At. Zion	19/2000 Lans	downe, Md.
Bal	permit. Departri		21. Signature of Funeral Service Licensee	22. Nama and Addrass of Facility Joseph L. Kus ZZZZ W. North	S Funeral H	tome 40.21216
			23a Part Enter the disease, or complications that caused the death	. Do not enter the mode of dying, such as cardiac	or raspiratory errest,	Approximate Interval Between Onsat and Death
	Physician /Medical Examiner	,		olunt and sharp frese consequence of):	force injurie	
	d ansit	Examiner	b	r es a consequence of):		
0,	a exectan and an an and an an and an and an an and an an an and an an an and an an and an an an an an and an an an an an an an an an an an an an		Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	es a consequence or).		
x 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Medical		es a consequenca of):		
Box	attending for use a	lan	d			
o.	She the	Physician/	Part II. Other significant conditions contributing to death but not rasu	Ilting in the underlying cause given in Pert I.		tributs to the cause of death?
ď.	5 8 8	by Pt			1 Yes 2 (No	3 Probably 4 Unknown
Records,	been s	Completed t			24e. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Re	age of the	Omo			1 2 Yes 2 □ No	1 XYes 2□ No
/ital		Bec	25. Was casa refarred to medical examiner?	26. Place of De	eth (Check only one)	
of Vital	Physician: this certific ral director,	To		ER/Outpatient 3 DOA Other: 4 Nursing H	fome 5 ☐ Residence 6 ☑Othe 28d. Describe how injury occurre	
	Ing After fune	tlon	1 Neture 5 Pending (Month, Vey Year)	Injury Work?	Subject was struct	thuith plunt exices
Division	i or Attanding after death. Director: Afte d in by the fune	Certification:	ST Could not be	ime, farm, street, tectory, office	28f. Location (Street and Number City or Town, Stelle) 211	er or Aural Route Number, Clifton Avenue
Ö	ital or ital or ital Dir ital Dir ital Dir		Reside	ence	Baltimore City	Maryland
	Hosp 24 hou Fune tiely fil	edical	(Check only 2 Medical Examiner: On the basis of examinet	wiedge, deeth occurred et the time, date end plece ion and/or Investigation, in my opinion, deeth occu	e, end due to the ceuse(s) and mai arred at the time, date end place, a	nner as stated. and due to the cause(s)
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Mec	29b. Signeture end title of certifier	29c. License number	29d. Data signed	(Month, Day, Year)
	0	V	Start A Wack	5 m. 0 O.C.M.E.	August	16, 2000
	200		30. Name and address of person who completed causa of deeth (Item			
-	de		Stephen S. Radentz,	111 Penn Street, Ba	ltimore, Maryla	nd 21201
	Sta Registr		31. Data filed Worth 202 Year 100	lure,		



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State of Maryland / Department of Health and Mental Hygiene

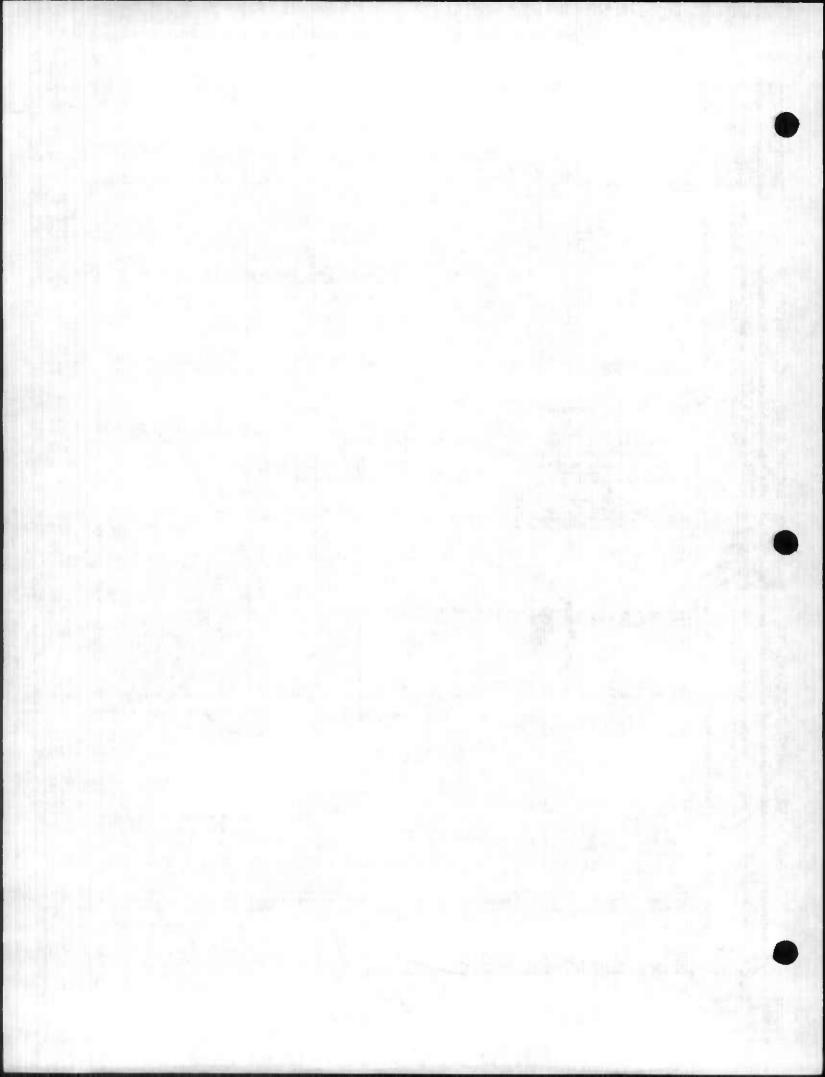
Certificate of Death

Reg. No.

00

26445

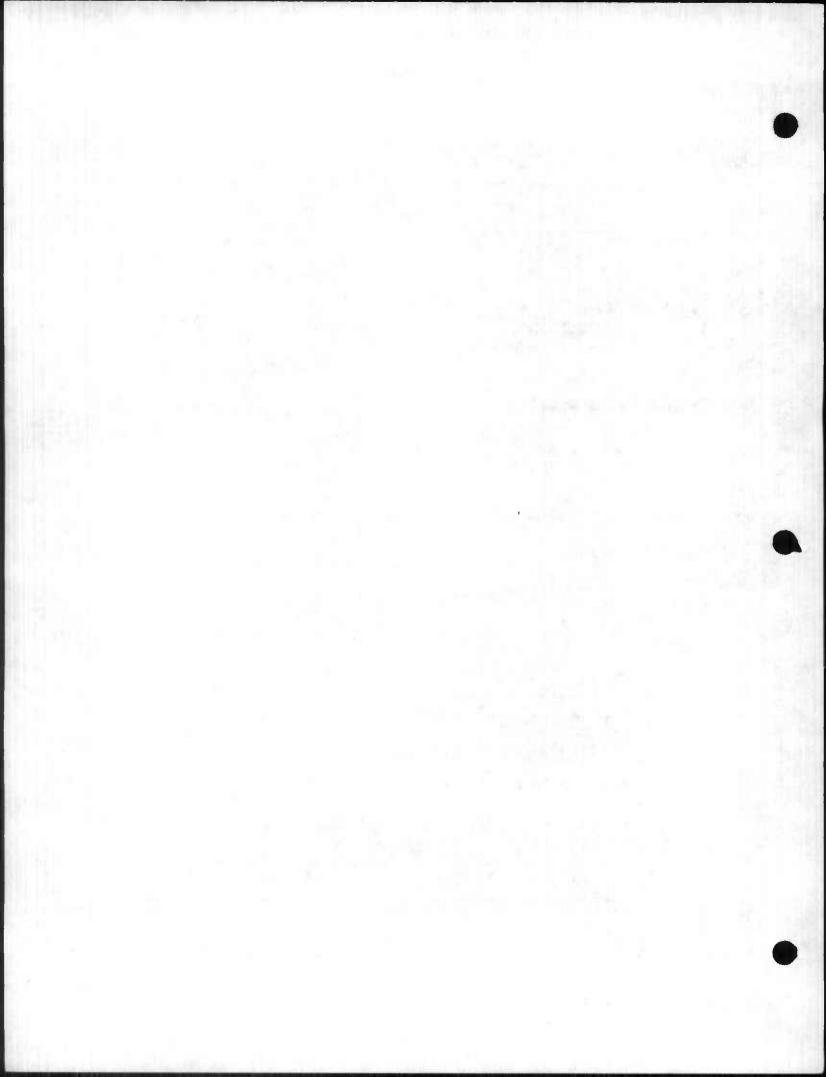
_						0011111	outo or i	- Journ		neg. No.		
	Dhariston		Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
40	Physician /Medical	_	Earl L. Bo	ooth					August	00 00		10:10 P.M.
	Examiner	40	Facility Name (If not institution, give s					b. City, Town, or Le				11215
	LAMINITE		427 W 11 2 2 . Dec	,				01 D		2	- 7	3 1
			137 Northdale Road Social Security Number 6. Sex		(In yrs. last bi	inthday) If I	Jnder 1 Yeer	Glen B	8 Date of Bir	th	e Aru	
	Funeral		10	M 2□F		Yrs. Mo	nths Deys	Hours Min.	(Month, Da	y, Year)		place (Stete or Foreign
	Director	2	18-36-5650		59				Jan. 1	, 1941	Mar	yland
	2	-	a. State 10b. County		10c. City, Tov	wn or Locatio	n				1	0d. Inside City Limits
	with the Maryla t or 23e-I show be notified at Director			2.2	0.3							1 ☐ Yes 2 No
	the Ma 23s-f s potified		Md. Anne Ar	undel	GIE	en Bur						
	Die ge	10	e. Street and Number			10	M. Zip Code			10g. Citizen of	what Cour	niny /
	6 th 16		137 Northdale Road	d				1060			.S.A.	
	or de	11	. Marital Status	Wes Decedent E Armed Forces?	ver In U,S.	13. Wes I	Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Bla	e - Americ ck, White,	
0	a toll R		1 Never Married 2 Merried	1 ☐ Yes 2 X N If Yes, Give	0		es 2X No	Specify:		Specif	v-	
21215-0020	Era Por		3 Widowed 4 Divorced	Year or Dates:			200 200	opeony.		Specif	Whit	e
5-6	TZ h		15. Decedent's Educ (Specify only highest grade		166	Decedent's	Usuel Occup	ation during most of work	ino	16b. Kind of B	usiness/In	dustry
21	The state of		Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO N	OT use retired	d)	w ng			
2	led within tygiens. Ner than it, the Me	5	12th	0			Sales			H&S B	akery	,
P	be file d othe event,		Father's Name (First, Middle, Last)			1-11-		18. Mother's Nam	e (First, Middle			
lar	parties o		Earl Booth					Dorothy	Cock	rall		
7	House H		Pa. Informant's Name/Relationship (Typ	ne. Print)	19	b. Mailing Ad	dress (Street	end Number or Rui			Stete. Zio	Code)
Ma	0 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			1								
	F 2 2 2	-	usan Booth (Wife)		of Disposition	rthdale	e Road G	Date Dur	20c. Location		nd 21060
more	P P P P P P P P P P P P P P P P P P P	20	1 Burial 2 Cremation 3 Re	emoval from Stete	cemete	ery, cremetor	y or other pled					
E	and and and and and and and and and and		4 ☐ Donation 5 ☐ Other (Specify)		Glen	Haven	Memor:	ial Park	8/25/00	Glen B	urnie	e, Maryland
a	E SAN S	21	I. Signeture of Funeral Service License	е			me and Addre					
8	88188		11/	11/1:			_	lyniak Fu		•		
		21	Da. Party Enter the disease, or complic	ations that caused	the death. Do	not enter the	Mounta mode of dyin	ain Road	Pasade or respiratory a	rest, Mary	Land	21122 Approximate
3	Physician	10	shock, or heart failure. List only on	e cause on each lin	Θ.							Interval Between Onset and Death
	/Medical	Im	nmediate Cause (Final	mal	1	1	5	11 Call	A.	1		10
	Examiner	di	sease or condition sulting in death)	116	19.510	tric	- m	all Cell	Dung	(ance	5 1	10 mos.
	DEPENDED A				Due to (or as a	consequenc	a of):		U		1	
	n and tal-transit		_ b									
	be executed bician and buriel-transit	Se	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events		Due to (or as a	consequenc	e of):					
68760,	o oc.	Ca Ca	ause. Enter Underlying									
87	certificate be exected by the physician and the burial-from the burial-from the burial-from the control of the burial-from the control of the burial-from the control of the burial-from the control of the burial-from the control of the burial-from the control of the burial-from the buri	the	at Initiated events sulting in death) Last		Due to (or as a	consequenc	e of):					
9	oding puse as											
SOX			0								1	
. 8	that the death led by the atte detached for V Physicial	Pa	rt II. Other significant conditions cont	ributing to death bu	t not resulting	in the underl	ying cause giv	en in Part I.	23b. Dld	tobacco usa co	ontribute t	o the cause of death?
0	by the								10	Yes 2 No	3 Pro	bably 4 Unknown
0.	signed ld be det								X			
Records,	requires that the death wen signed by the atte hould be detached for									en eutopsy	24b. W	ere autopsy tindings
00	been si should should								perfo	ormed?	CC	railable prior to empletion of cause
36	has b											death?
=	F ag O								10	Yes 2 No	1 8	Yes 20No
Vital	Physician: The this certificate ral director, page TO Be CO		. Was case referred to medical examiner?					26. Plece of Deal	h (Check only	one)		
2	this ce al dire		1 Yes 2 No	ospitel: 1 Inpatier	nt 2 ER/O	utpatient 3	□ DOA Oth	er: 4 Nursing Ho	me 5 Resi	denca 6 🗆 Oti	her (Specia	fy)
100	erth Jeral		. Manner of Death	28e. Date of Injur (Month, Dey	y 28b.	Time of fnjury	28c. Injur Wor	y at	28d. Describe	how injury occu	rred	THE STATE OF
0	th: Ah e fur e fur Ah		1. Netural 5 Pending 2 Accident Investigation	(World, Day	r evary	N		Yes 2□No				
/IS	Attending or death. Sector: After fune by the fune lifecation		3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home, f	arm, street, f	actory, office				ber or Run	al Route Number,
Division	tal or Attending P rs after death. al Director: After t ed in by the funers Certification:		4 Homicide	building, efc	. (Specify)				City or To	wn, Stete)		
	STEO U	29	a. Certifier TE Certifying Physi	cien: To the best o	f my knowledo	e death occ	urred at the tir	ne, date end piece	and due to the	cause(s) and m	enner as s	stated.
	in 24 hours he Funer pletely fill edical		(Check only 2 Medical Examin		examinetion e							
	within 2 to the comple	20	b. Signeture and Interd certifier	and memor ste	100.		29c. Licens	e number		29d. Date signs	ad (Month	Day Year)
	F 3 5 8 ()	23		nn	2 1	_	1	3,~~)	1		
	V.V.		(Done)	1/11/	1	/	0.	11531		Hugh	St	22,000
	Mb	30	Name and address of person who cor	npleted cause of de	ath (Hom 23a)	(Type, Print)	1)				
	JA	(5	sussel/CLIDe	Luca 1.	9. 1600	25.	Lidin	Highmy	Ste602,	Flend	win	22,2000 W.21061
	State	31	. Date filed (Month, Dey, Year)		r's Signature	1	1	5) /	,		,	
	Registrar		AUG 2 2 200	Ulan		P	spork	3				



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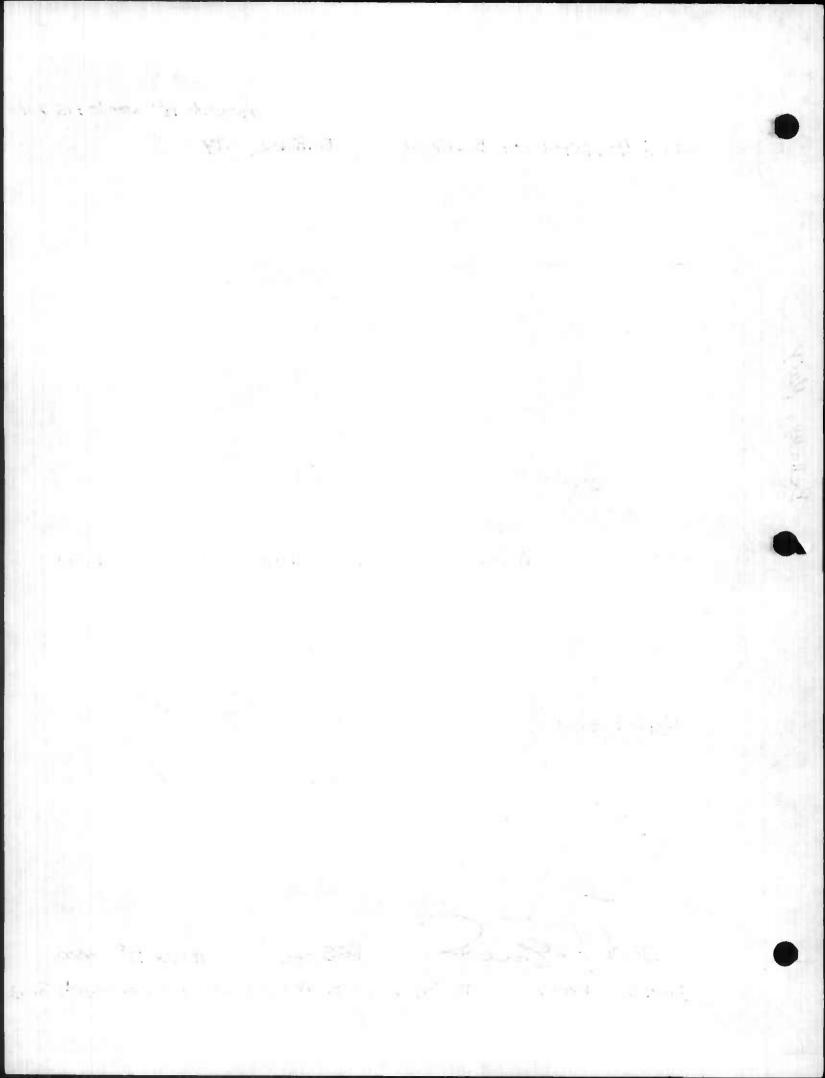
State of Maryland / Department of Health and Mental Hygiene 00 26446

				Certificate of	Death	Rec	a. No.	20440
		1. Decedent's Name (First, Middle, Las	(1)			2. Date of Death		3. Time of Death
	Physician /Medical	Dorothy	Virginia	Burns		August	271,2000	8:00A.M
	Examiner	4a Facility Name (If not Institution, give	street and number)		4b. City, Town, or L	ocation of Death	4c. County of Death	
1		Oak Lodge Assi	isted Living		Pasad	ena	Anne An	rundel
	Funeral	Social Security Number 6. S	TH ONE	Months Days		8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign ntry)
ш	Director	214-38-5005	□M 2 K)F 7	9 Yrs.		Nov. 20	0,1920Vii	rginia
	2	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Location				10d. Inside City Limits
	sho of		Arundel	Pasadena				1 ☐ Yes 2 No
	or 28a-1 s	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	intn/?
	23a or 28a-f show		ourt		1122	100	U.S.A.	nuyr
	r Home 23	11. Marital Status	12. Was Decedent Ever in U,			ecify Yes or No-	14. Race - Ameri	can Indian.
	Hems Institute	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	S. 13. Was Decedent of If Yes, specify Cu	ban, Mexican, Puerto	Rican, etc.)	Black, White,	
320	by F		If Yea, Give Year or Dates:	1 ☐ Yes 2 🗷 No	o Specify:		Specify: Whi	ite
Maryland 21215-0020			ucation	16a. Decedent's Usual Occi	upation	16	6b. Kind of Business/In	ndustry
215		(Specify only highest gra-	de completed) College (1-4or 5+)	(Give kind of work don life. DO NOT use retir	e during most of work red)	ing		
2	giene.	12	0	Hous	ewife		Home	
pu :	T S S				18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
Va a	marked	Benjamin	Thomas		Blan	che	Grove	9
a	and and and and and and and and and and	19a. Informant's Name/Relationship (7		19b. Mailing Address (Street				
	and n 27 ner tr	Robert C. Burn		1520 Puffi	n Court,	Pasade	na, Mary	land 21122
altimore	or off Her	20a. Method of Disposition 1 Burial 2 Cremation 3 D	04	ace of Disposition (Name of emetery, crematory or other pi	/ace)	Date 20	Oc. Location - City or T	own, State
E	2 5 5 ×	4 Donation 5 Other (Specify	Gr	eenmount Ce	-	8-22-00	Baltimor	ce, Marylan
a	Department Important any Injury phose.	21. Signature of Funeral Service Licen	500	22. Name and Add	27	04 Moun	tain Rd.	Pasadena
m	XOE & B	Themas S.E	tomme	McCully	-Polynia	k Funer	al Home I	P.A. Md211
	1111	Part I. Enter the disease, or comp shock, or heart failure. List only	Meations that caused the death	. Do not enter the mode of d	ying, such as cardiac	or respiratory arres	it.	Approximate Interval Between
P	hysician						51.2	Onset and Death
	/Medical Examiner	Immediate Cause (Final diaease or condition	. Dama	NTIA				4 yr. Break
		resulting In death)	Due to (or	as a consequence of):				1
1	n end ial-transit Examinet		b. / / UL11	PLE JNF	PRC75			
	end Hran	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequence of):				
09	physician and sthe burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c					
68760	nincate be executed no physician end as the burial-transi	that Initiated events resulting in death) Last	Due to (or	as a consequence of):				
×			d					
Вох	d by the ettendietached for use					1		
0	y the sched	Part II. Other eignificant conditions co			- 0			to the cause of death?
0	deta V		LARUTIC CA	ROISVASQUE	K DISEM	1 Yes	2 DNo 3 Pro	obably 4 Unknown
sp.	been signed by the estend should be detached for us.		and Mad	John Stranger		24a. Was an		Vere autopsy findings
00	sate has been s page 2 should	(L) 17491	437 11/135	>		performe	0	vailable prior to ompletion of cause f death?
l Re	ate has b	O Received	100 TWO	ASLL.		4 🗆 V***		
<u>a</u>	certificate rector, pag	25. Was case referred to medical	IN 7 1 14 01c	1316	00 81	1 Yes		Yes 201No
of Vital Records,	ls certific director,	examiner?	Hospital:	ER/Outpatient 3 DOA	Whor:	h (Check only one	ca 6 Other (Spec	Assisted
O	5 2	27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Inj		28d. Describe how		""Living
on	th After e funer	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)		ork?			
Division	ster death. Director: After in by the fune	3 Suicide 6 Could not be	200. Place of injury - At no	me, farm, street, factory, offic	0		et and Number or Rui	ral Route Number,
S S	rs ster death. al Director: After tied in by the funer. Certification:	4 Homicide	building, etc. (Specify)		City or Town,	State)	
-	y fille		vaician: To the best of my know					
	the Funeral npletely filled	(Check only 2 Medical Exam	iner: On the basis of examinati and manner stated.	ion and/or investigation, in my	opinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
	within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	29b. Signature and title of certifier	1	29c. Lice	nse number	290	d. Date signed (Month	. Day, Year)
	,0	Mulul J.	lminen	\wedge	2170	3	08/2/1	2000
~ 1	1	30. Name and address of person who d	completed cause of death (Item	23a) (Type, Print)	1.0		0 0	11
(XO.	MICHAEL E	U GARAHY	, 86511	T. SMOU	LWSSOF	IP, PAS	ADENA MA
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	land.			



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Physician		ıma (First, Middle, La	nst)					2. Data of De Month	Day	Yaa	3. Time of Deal
/Medical	Marv	M. Bell	amy					AUGU.	J 18	20	00 10:15;
Examiner		(If not institution, gh	ve street and number)	. /1.			4b. City, Town, o	Location of Deat	h 4c. Co	ounty of De	eath
	5. Social Security	HOSPY		e (In yrs. last		If Undar 1 Yaa	Bath Was	S. 8. Date of Bi	dh	0.0	Sinthalana (Ctata on En
Funeral Director	238-48-9	645	1□ M 2□XF 90			Months Days			ay, Year)		Birthplace (Stata or For Country) rth Caroli
A 11	Usual Residence 10a. State	of Decedent 10b. County		10c. City, To	own or Loca	ation					10d. Inside City Lin
28a-f sho	N.C.	Columbus	S	White	eville	e					1 ☐ Yes 2□
a or 28a-1 show	10e. Street and N	lumber 456	LEGION DE	RIVE F	TIXE	10f. Zip Coda			10g. Citizer	of What	Country?
me 23a	465 Lei					28472			U.S.		
	11. Marital Status		12. Was Decedent Armed Forces?	Evar in U,S.	13. W	as Decedent of Yas, specify Cu	Hispanic Origin? (ban, Mexican, Pua	Specify Yes or No rto Rican, etc.)	0- 14.	Black, W	merican Indian, hile, etc.
vatural, or the		arried 2 Married 4 Divorced	If Yes, Give Year or Dates:	No	10	☐ Yes 2 💢 No	Specify:		Sp	ecity:	Black
Par Par		15. Decedent's E	ducation	16	Ba. Decede	nt's Usual Occi	upation		16b. Kind	of Busines	ss/Industry
- La	Elementary/Se	ecify only highest graceondary (0-12)	ada com <i>pleted)</i> College (1-4or 5	5+)	life. DO	O NOT use retir	e during most of w	orking			
Hygien ther th	8				House	ewife				maker	c
d other event, Be C	17. Father's Name	e (First, Middle, Last	1)					ame (First, Middle		mame)	
is marked o			CT = D.101		Ob. 84-W	Add (0)		(Unknown)		- Curt	Zin Codel
3 45 10 40		Name/Relationship (Douglas /					et and Number or I				
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Depar Impor		= 0	112		461	1 Park	Heights	Ave. Ba	ltimo	re. M	laryland ₂₁₂
and the same	23a. Part1. Enter	r tha diseasa, or com	nplications that caused	the death D							Approximate
hysician	Shock, or he			a tire occiti.	o not anto	the mode of of	ring, such as cardi	ac or respiratory i	arrost,		
		eart failure. List only	one cause on each lin	ne.	o not anter	are mode or o	ring, such as cardi	ac or respiratory i	a1105t,		Interval Between
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month ar tuo 2000 4c/County of Deeth Fecility Nerne (If not Institution, give street and number) 4b City, Town, or Location of Peeth Knoll KUISIM CA more If Under 1 Yee 24 Hrs. Sociel Security Number 6. Sex 8. Dete of Birth (Month, Day, (kuyis. last birthday) Birthplece (State or Foreign Days Hours Months 1 M 2 F Usuel Residence 10b. County City, Town or Location 10d. Inside City Limits 1 Pres 2 No MARY/AND 10e, Street and Number MORE 10f. Zip Code 100 Citizen of Whet Country? 0 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cubar, Mexican, Puerto Rican, etc.) Wes Decedent Eve Armed Forces? 11. Maritel Stetus 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Specify. 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired). 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) amin 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) FORGE 0 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Neme of emerlery, cremetory or other place) RANCES TO 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriei 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Tons 21. Signature of Funerel Service Licensee 22. Neme end Address of Facility MARShall (A ARSHA W md 2/22 23e. Fant. Enter the disease, or complications that callsed the deeth. Do not enter the mode of dy shock, or heart feiture. List only one cause on each line. 410 such es cardi Approximete Intervel Between Onset and Deeth Immediete Ceuse (Finel disease or condition resulting in deeth)

Physician /Medical Examiner

The law requires that the deeth certificate be executed

ate has been signed by the page 2 should be detached

this certificate

After

deeth.

eftar deeth

within 24 hours of To the Funerel C Hospital

funeral

filled in by

completaly

or Attending Physician:

à

Completed

Be

2

Medicai Certification:

Box 68760.

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be 10

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mantal Hygiens. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumetic event, it is Helical Examinations.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner the attending physiclen and hed for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of):

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown

24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an eutopsy performed?

1 ☐ Yes

26. Piece of Deeth (Check only one)

1 ☐ Yes 2 No

	Wes case referre exeminer? 1 ☐ Yes 2 N		medical
27.	Manner of Deeth	5 [] Pendin

Hospital:

30. Neme end eddress of parson who completed cause of deeth (Item 23a) (Type, Print)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 ☐ Accident
3 Suicide
4 Homicide

5 Pending investigation 6 Could not be determined

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only onel

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as steted.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier

29c. License number

1 Yes

2 No

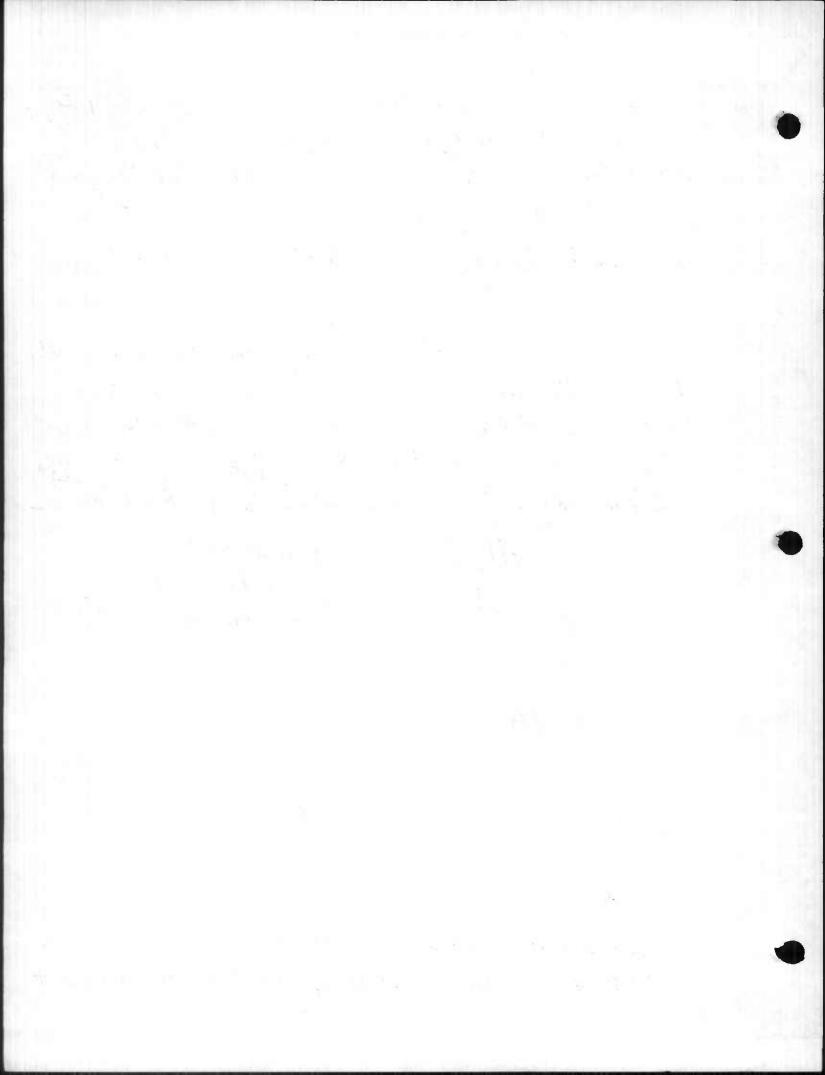
29d. Dete signed (Month, Day, Year)

31. Date filed (Month, Day, Year) AUG 22 2000

32. Registrar's Signeture

Macon

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** William Doyd 5:00 AM August 2000 21, /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Care Baltimore Hospice lowson If Under 24 Hrs. 8. Date of Birth 6. Sex 1 M 2□ F If Under 1 Yeer Birthplace (State or Foreign Country), 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days May 215-42-1293 Director Marulan Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Hall Directo Maryland Baltimore 10eCS reet and Number 10f. Zip Code 10g. Citizen of Whet Country? 21234 9303 Roa USA Woods Funerai 12. Wes Decedent Ever in U.S. Amped Forces?

1 X Yes 2 No If Yes, Give Year or Dates: 1960 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Meritel Status 1 Never Merried 2 Married Maryland 21215-0020 1□ Yes 2X No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then. intery/Secondary (0-12) College (1-4or 5+) lementery/Secondary to Maintenance Retirement Community Mechanic other 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If them 27 is marked oth any Injury or other traumatic even potes. 1 and 2 should be Health and Mental Mantre Cowan Andrew 19e. Informant's Name/Relationship (Type, Print) 9b. Meiting Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 606 Baltimore Ave, suite 203 MD Robert Winkler Lawyer 10 WSOn MD 20c. Location - City or Town, State 21204 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) Date 1 Buriei 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Aug 22, 12000 Green Mount Cemeter 22. Name and Address of Failing Brian T. Chisholm Funeral Services of Dulancy Willey 21. Signature of Funerel Service Licensee 200 E. Padonia Rd. Timonium. First Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory make, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final months diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieled events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. The law requires that the death certificate be Physician/Medicai Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings 24e. Wes an eutopsy performed? svailable prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 2 CHO this certificate Physicien: Be 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) Hospical 10 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Medicai Certification: 28c. Injury et Work? i or Attending P after death. I Director: Attar t d in by the funera 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral L 29a Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and menner stated. 9 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of 2 25205 grest 21 2000 of person who completed course of death (Item 23a) (Type, Print) (dism(31. Date filed (Menth, Bay, Year) 32. Registrer's Signeture Registrar AUG 2 2 2000 DHMH 16 Rev 6/95

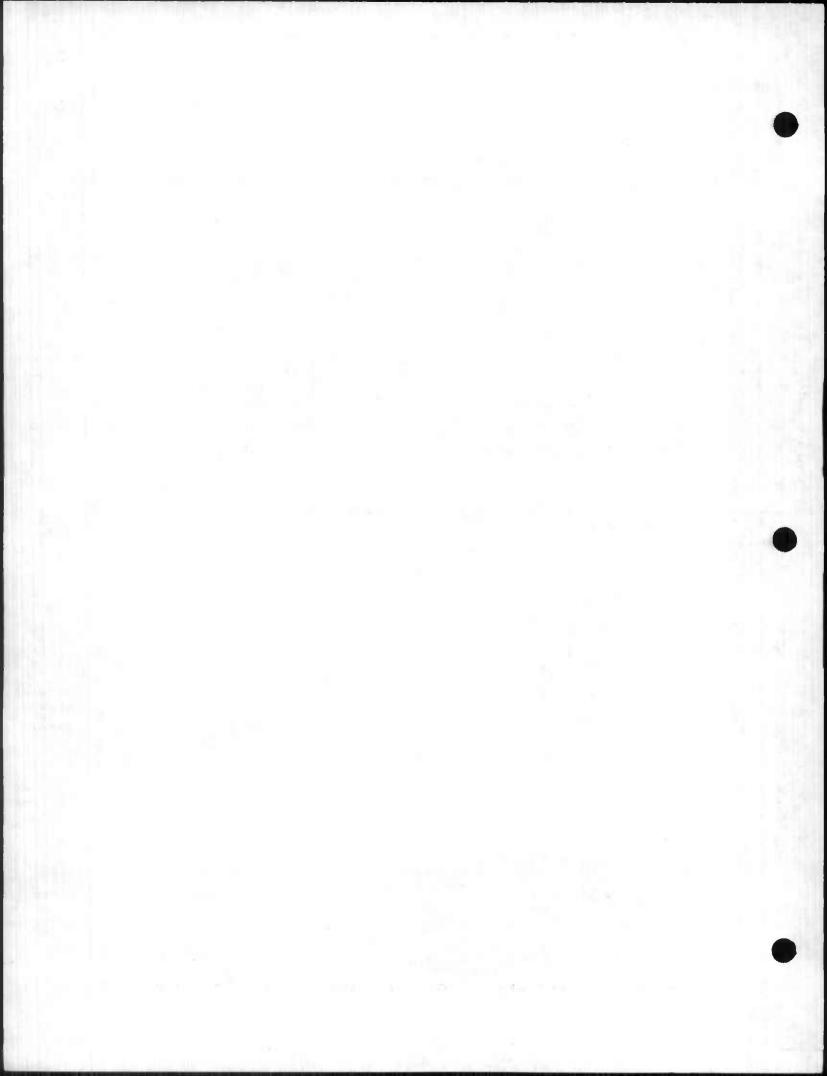
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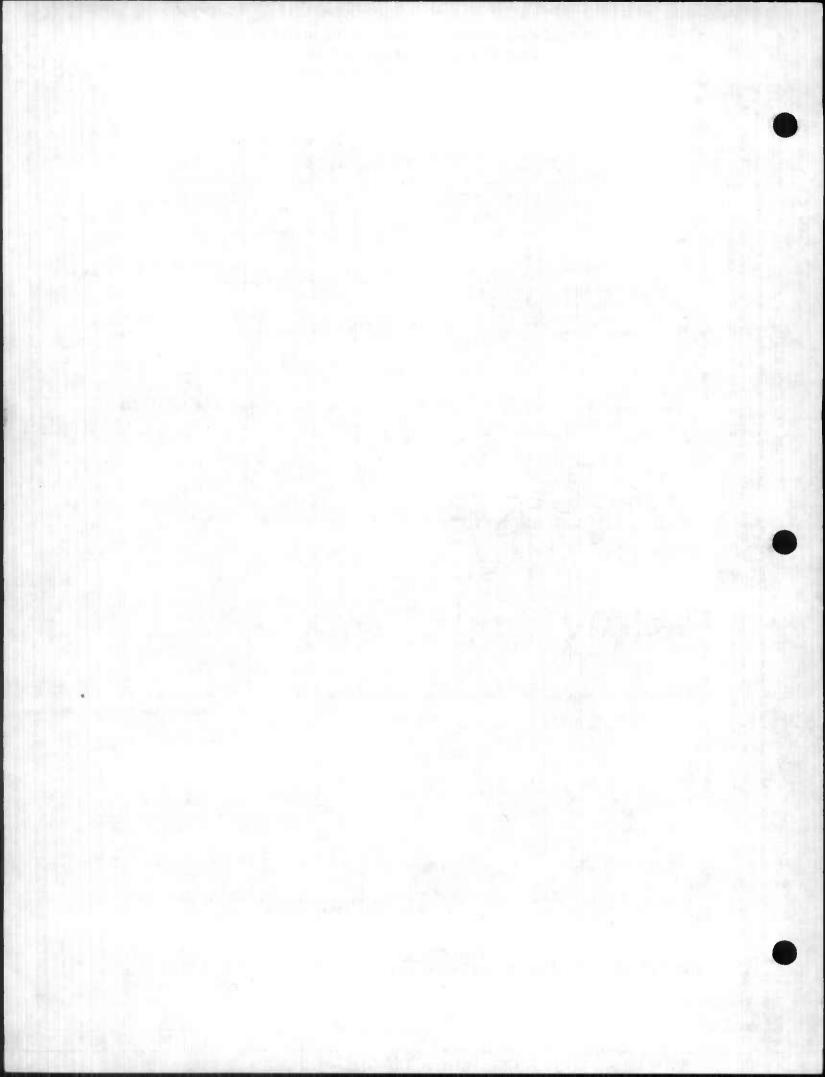
State of Maryland / Department of Health and Mental Hygiene 00 26450

			Certificate	e of Death	Re	eg. No.		
	1. Decedent's Name (First, Middle, L	ast)			2. Date of Deat	h	3. Time of Death	
Physician	111111111111	E BOLL	1116		Month AUGUS T	Dey Year 18 2000	01:00	
dical niner	4a Facility Name (If not institution, gi		17110	4b. City, Town, or I		4c. County of Deal		
Hei			A.,_	BALTIM	RE			
	SHALL A DI W DEWEDERE ME							
	12M 2DF Yrs Months Deys Hours Min. (Month, Day, Year)							
	Usuel Residence of Decedent	100			HUGUST	1,118	0/7/0	
	10a. State 10b. County	10c. City	, Town or Location				tOd. Inside City Limits	
	MIN RILLY	MORE RA	NUALLS	Tall 11			1⊟Yes 2□No	
r herre 23a or 28a-t e plant must be notified Funeral Directo	10e. Street and Number	mone por	10f, Zip		1	0g. Citizen of Whet Co	untry?	
	1177 - 111-	0 -2 0 0	0			11-	0	
ŀ	11. Merital Status	12 Was Decedent Ever in II	S 13 Was Decen	Sent of Hispanic Origin? (S	necify Yes or No-	14. Race - Ame	rican Indien	
	1 Never Merried 2 Married	Armed Forces!	12. Wes Decedent Ver in U.S. Armed Forces III 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Put II Yes, Give II Yes, Sive II Yes 2 No Specify:				the state of the s	
	3 Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:					ZACK	
1			16a Dacadent's Heur	I Occupation		16b. Kind of Business		
-	15. Decedent's E (Specify only highest gi		16a. Decedent's Usua (Give kind of wor life. DO NOT us	rk done during most of wor	king	TOD. TAILO OF DUSINGSS	moderny	
	Elementery/Secondery (0-12)	College (1-4or 5+)	C 2 1		n	MANNINH	RHORINIG	
	17. Father's Name (First, Middle, Las	e)	DEEEL	WORKE	ne (First, Middle, M		CTORING	
	Trather's Name (First, Middle, Las			To. Mother's Nen	I 316 A	1 a /		
	UUNUS	BOLDINE		014	-11100	///		
and a ma	t 9a. Informent'a Neme/Reletionship	1. 1. 1		(Street and Number or Ru		2 11	CIP Code)	
	CAROLYN &	VACKSON		REEDERSC	Up, CIR	. BALTO,	MU 21133	
	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 l	70 1/ 01/	lece of Disposition (Nan emetery, cremetory or o	ther plece)		20c. Location - City or	22 /	
	4 Donation 5 Other (Spec	ify)	100WT Z	10 N	8-24-00	LANDSCLOU	vue, ma	
	21. Signeture of Funeral Service Lice				WELL		Al Kome	
	111.0000 c	= W 0) 4600	SLIGHTER EX	11 516	nts MU	ENIUE	
	22a Parti Enter the disease or our	redications that sourced the death	13146	timoret	m	0 2/2	Approximete'	
	23a. Pertt. Enter the disease, or cor ahock, or heart feilure. List only	one ceuse on each line.	i. Do not enter the mod	e of dying, soci es carope	or respiretory em	5 31,	Interval Between Onset and Death	
	1							
	Immediate Cause (Final disease or condition	SEPS	115					
-	resulting in death) Due to (or as a consequence of):							
		h						
	Sequentially list conditions,	Due to (o	Due to (or es a consequence of):					
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.								
Cause (Disease or injury that initiated events that initiated events resulting in death) Last Due to (or es a consequence of):								
		d						
	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying c	ause given in Pert f.	23b. Did to	bacco use contribute	to the cause of death?	
					1 D Y	08 20 No 3□P	robably 4 Unknown	
cata has been signed page 2 should be de Completed by F					24e. Wes e		Were eutopsy findings	
			Maria Control		perform	med?	available prior to completion of cause of deeth?	
-						4/		
					1 O Y	es 20/No	1 ☐ Yes 2 ☐ No	
	25. Was case referred to medical examiner?	Monitely 6			eth (Check only or	le)		
	1 Yes 2 No		ER/Outpetient 3□ DC			ence 6 Other (Spe	ecify)	
	27. Manner of Death 1 Neturel 5 Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of 2	28c. Injury et Work?	28d. Describe he	ow injury occurred		
	2 ☐ Accident investigetic	on	М	1 Yes 2 No				
	3 Suicide 6 Could not determined	28e. Piece of Injury - At he building, etc. (Specify	ome, farm, street, factory	y, office	28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,	
		Johnson, etc. (Opocin)			, 3. , 3			
		hysician: To the best of my know						
2000	(Check only 2 Medical Exa	miner: On the basis of exeminer and menner steted.	non end/or investigetion	, in my opinion, deeth occu	rred at the time, d	ete end piece, and du	e to the cause(s)	
	29b. Signeture end titlé of certifier	1	290	c. License number	2	9d. Date signed (Mon	th, Day, Year)	
	11/19	6.1		19678		A	8 2000	
	Mush C	cucher	00s) (T D : ::	17618		AUGUST 1	,2000	
	30. Neme and address of person who			A			The state of the state of	
				DEKE AVE, B	ALTIMORE	MD 212	15	
9	31. Date filed (Month, Day, Year)	32. Registrer's Signe	ture	1 ,				
rar	Alig 2.5	2 2000 Denes	Jan D	20 acks				



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					State of t	viai yiai i		rtificate of	Death		Reg. No.	0 2	26451	
	Physicia	an	1. Decedent's Name		rst)					2. Date of De Month		Year	3. Time of Death	
Ą	/Medic	_	ANN					COLEMAN		AUGUST		000	20:00	
	Examin	er	4a Facility Name (# THE J		re street and numb KINS HOSE				4b. City, Town, or BALTIMOR			of Death		
	Funeral Director		5. Social Security No. 220-36-8	3862	Sex 7.	Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, De 02-16			lace (State or Foreig try) SC	ראך
	Tang Man		Usual Residence of 10a. Stata	10b. County		10c. Cit	y, Town or Lo	ocation				1	Od. Inside City Limit	s
	Mary and ab	ctor	MD	NA		Ва	ltimo	ore					X Yes 2□N	0
	with the Marylan 3e or 28e-f show st be notified at	il Director	10a. Streef and Nun 2138 A	iken St	reet	e i i		10f. Zip Code 2 1 2	218		10g. Citizen of W	/hat Coun	try?	
020	urs after death w af, or itsms 23a Examiner must	by Funera	11. Maritai Stafus 1 Never Marris 3 Widowed	ed 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Yaar or Date	os? No		Was Decedent of I If Yas, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (S an, Mexicen, Puerl Specity:	Specify Yes or No to Rican, atc.)	Blac	Americ k, White,		
5-0	72 ho natura	pete	(Spec	15. Decedent's E	ducetion ade completed)		16a. Dece	dent's Usual Occu	pation during most of wo	rking	16b. Kind of Bu	siness/Inc	lustry	
Maryland 21215-0020	d within pene. r than the Mes	Completed	Elementary/Second 10th Gra	ndary (0-12)	College (1-4 NA	or 5+)	Cook		during most of wo		Baltimo	ore	Public S	3c
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yla	Marita marka marka	10	Tommie		Gamble				Sallie			ris		
Mai	d2st than 7 is n		19e. Informent's Na Isaac	colem					street				and 212	18
Baltimore,	if of Heal		20a. Method of Disposition 20b. Place of Disposition (Neme of cematery, crematory or other place) 20c. Location - Cematery, crematory or other place)								City or To	wn, Steta		
計	ritmer relant		4 ☐ Donation 21. Signature of Fu	5 Other (Special Service Lice		Ar		2. Name and Addre	4 80 445					•
Ba	Dep was		1 Tue	-Cho	and a		·	WM.C.Man	ch FH]	1101 E.	North		d 21202 nue	
100			23a. Part1. Enter the shock, or hear	e disease, or com t tailure. List only	plications that cau	sed the deat h line.	h. Do not en	ter the moda of dyi	ng, such as cardia	c or respiretory a	arrest,	1	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (disease or condition	Finel	RENAL	FAILU	RE						TWO WEEKS	
	Examiner	-	resulting in death) Due to (or as a consequence ot):										TEN YEARS	
	and -transit	Examiner	Sequentially list cor	nditions,	b	Due to (c	r es a conse	quenca of):						
68760,	ficate be executed physician and is the bural-transit	dicalE	Sequentially list confrance, leading to improve the cause. Enter Under Cause (Disease or that initiated events		c		TERY D	DISEASE quanca of):					TEN YEARS	
Вох 68	5 0 5	_	resulting in death) L	ast	d									
	death certi	iclar	Part II. Other algnifi	cant conditions	contributing to deat	h but not ras	ulting in the u	undertying ceuse gi	iven in Part i.	23b. Did	tobacco usa cor	tributa to	the causa of deat	h?
P.0	that the de ed by the detached	/ Physician/M								10	Yea 2 No	3 Prof	bably 4 Unkno	wn
Vital Records,	been sign should be	Completed by							X		s an autopsy ormed?	av	ere autopsy findings aileble prior to mpletion of causa death?	
E E	The i	Com								10	Yes 2 No	18	Yes 2□ No	
Vita	Physician: The lav this certificate has ral director, page 2	Be	25. Was cese referrexaminer?		Hospital:			O	hor:	ath (Check only				
o	Phys ral di	7: 70	1 ☐ Yes 2 ☐		28a. Date of	Injury	ER/Outpatie	nt 3L DOA	4 Li Nursing I	,	idence 6 Oth		γ)	
ion	Attending Ph r death. ector: After th by the funeral	atlor	1 DNatural 2 Accident	5 Pending investigation		Day Year)	Injury		ork?]Yes 2⊟No					
Division	i or Attendi after death Director: A d in by the f	Certification:	3 Suicide 4 Homicide	6 Could not be detarmined	289. Place of	Injury - At he, etc. (Specif	ome, farm, st	reet, factory, office	Unity		(Street and Numb wn, State)	er or Rure	I Route Number,	
	Hospita 4 hours Funeral tely fille	edical C	29a. Certifier (Check only one)	Certifying Pl	miner: On the basi	s of examina	wledge, deat tion and/or in	th occurred at the to	ime, date and place opinion, deeth occ	e, and due to the urred at the time,	cause(s) and me , date and place,	nner as a	tated. tha ceuse(s)	
	within 2 To the	Med	29b. Signature and	Itla of certifier	and menner	A A		29c. Licen	sa number		29d. Data signe	d (Month,	Day, Year)	
	10		M	wine	al or	telle	Dur	RES	-000		AUGUST	16,	2000	
	OB		30. Name and addre MELISSA					Print) HOSPITAL	600 NOR	TH WOLFE	MARYL STREET		21287 TIMORE	
	Sta Registr	-	31. Date filed (Mont		2 2000	istrar's Signe	iture	B A	books					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day Year CUCINA Edith August 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Balt-more N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 26,1923 Maryland GENESIS Eldercare caton manor 7. Age (In yrs. last birthday) If Under 1 Year Months Deys 5. Social Security Number 6. Sex Birmplece (State or Foreign Country) Deys 1 M 2 XF 215-18-3871 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 Yes 2 No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 1717 Jackson Street U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondery (0-12) Paper Factory 12 Factory Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Moon John Smith Edna 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1717 Jackson Street Baltimore, MD. 21230 Edna Newman- Daughter 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State Burial 2 ☐ Cremetion 3 ☐ Removel Irom State 8-23-00 Baltimore, MD. Voshell Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Charles L. Stevens Funeral Home Inc. 21. Signature of Pherel Service Licens 21230 1501 E. Fort Avenue Baltimore, MD. the process of the course of the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, and only complications also on each line. Approximete Intervel Between Onset and Death reulin Dependent Diabetes Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Ho 3 Probably 4 Unknown Disorder. 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 Yes 2 No 25. Wss case referred to medicel axaminer? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner Examiner

mportant: If Ilam 27

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

Funeral

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28s-f:

b

Berns 23a

'natural', or

Baltimore, Maryland 21215-0020

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Pages 1 and 2 should be Health and Mental

physician and the burial-transit Box 68760 the death certificate be P.0. Records. Division of Vital this

Physician/Medical

by

Completed

Be

2

Certification:

Medical

27. Menner of Death

1 PNetural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

To the Hospital or Attanding Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

State

nou 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 24 lan 31. Date filed (Month, Day, Year)

AUG 22

2000

29b. Signature and introof certifier

5 Pending investigation

6 Could not be determined

PHNIS

Jener

28a. Dete of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

70555

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

28c. Injury at Work?

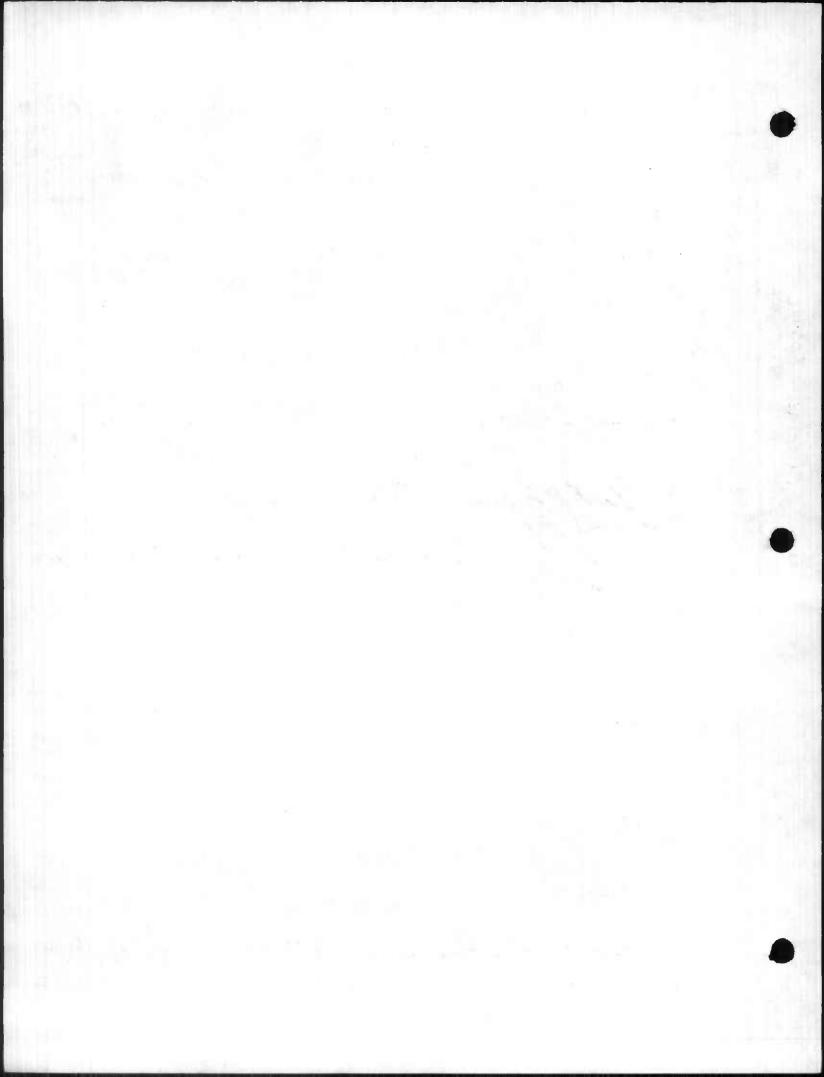
1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner steted. 29d Date signed (Month, Day, Year) 2000

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

East Fort Ave, Bolto 901 21236 32. Registrer's Signeture

28d. Describe how injury occurred

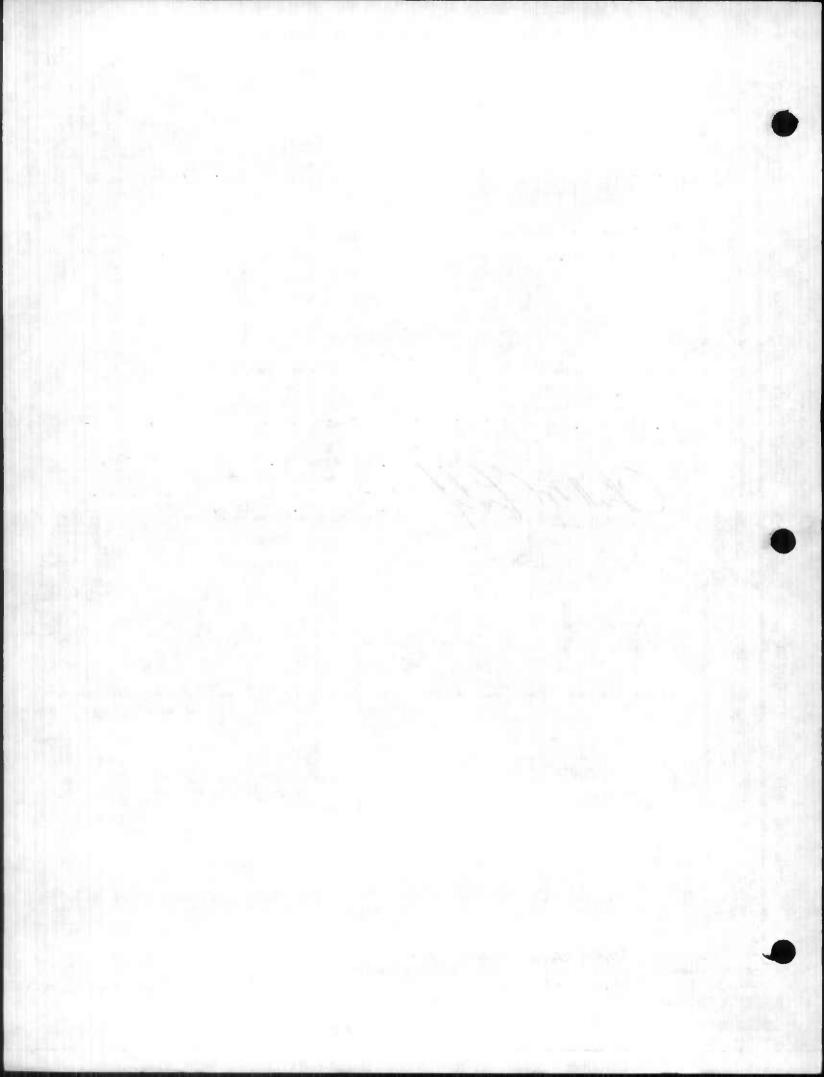


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		State of Maryland		nt of Health and te of Death		00	26453			
Physician	Decedent's Name (First, Middle, La.	Lillian	Danowski		2. Date of Dec Month	Day	Year			
/Medical Examiner Funeral Director	4a Facility Name (II not institution, gives 1) 5. Social Security Number 1 218-09-5774	e Hospital Cer	ter st birthdey) If Under Yrs. Months	Rosedo er 1 Yeer If Under 24 Hrs	Location of Death Location of Death B. Dete of Birt (Month, De	Balti	of Death MOCE 9. Birthplace (State or Fore Country)			
	Usual Residence of Decedent 10a. State 10b. County	1100 City 3	Town or Location							
tor 28a-1 show be notified at Director	Maryland Bal	timore	TOWN OF ECCANON	Dundalk			1 ☐ Yes 21 ☐			
	10e. Street and Number 839 Jaydee Avenu		10f. Zi	21222						
Examiner must by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Dece If Yes, spo	edent of Hispenic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race Blace	e - American Indian, k, White, etc.			
Completed	15. Decedent's Ec (Specify only highest gre Elementery/Secondary (0-12)	lucation de completed) Collège (1-4or 5+)	16a. Decedent's Usi (Give kind of w life. DO NOT	ork done during most of wo use retired)	orking	Reg. No. ath Day Year 9				
marked other matic event, I To Be Co	6 Years 17. Father's Name (First, Middle, Last) James W. Zielins		nousewa	18. Mother's Na	me (First, Middle,	Maiden Sumem				
25	19a. Informant's Name/Relationship (Mr. Albert R. Da			s (Street end Number or Fi Sleepy Hollov						
nt: If Ilam 27 ry or other t	1 Burial 2 Cremetion 3 Demoval from State cemetery, cremetory or other piece)									
amporta any inju ance	21. Signature of Furono Service Chargase 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222									
ysician Medical Andrei-Itausit principles and princ	Immediate Cause (Finel disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. 5ep515 Due to (or a	is a consequence of):						
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signed by the d be detached d by Physical	Potent Significant Continuous Co	ontributing to death but not result	ng in the underlying	ceuse given in Fait I.	1 🗆 1					
s been 2 shoul			1.56				available prior to completion of cause			
certificate has been signed by the ettending phrector, page 2 should be detached for use as the Completed by Physician/Med			2		101		1 ☐ Yas 2 ☐ No			
il director,	25. Was case referred to medical examiner?	Hospital: 1⊠Inpatient 2□EF	VOutpatient 3□ D	Other:	eth <i>(Check</i> only o		er (Specify)			
	27. Manner of Death 1 SNaturel 5 Panding 2 Accident investigation	28a. Date of Injury (Month, Dey Year)		28c. Injury at Work? 1 Yes 2 No						
ours after death. eral Director: After t filled in by the funer il Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At home building, etc. (Specify)	e, farm, street, facto	ry, office	28f. Location (S City or Tox	Street end Numb vn, Stete)	Day Year 3. Tima of Death 3: 30 cm 4c. County of Death Baltimore 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1			
within 24 hours after To the Funeral Direc completely filled in by Medical Certif	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	yelcian: To the best of my knowle niner: On the basis of examination and manner stafed.	edge, death occurred n and/or investigation	d at the time, dete and place, in my opinion, death occ	e, and due to the urred at the time,	cause(s) end ma dete and place,	nner as stated. and due to the cause(s)			
To the comp	29b. Signefure end title of certifier	chemman		C. License number		29d. Date signer	1			
O,	30. Name and address of person who of	completed ceuse of death (Item 2:	3a) (Type, Print)			Baltin	2123			
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Signatur		Locals			, ,			

DHMH 16 Rev 6/95

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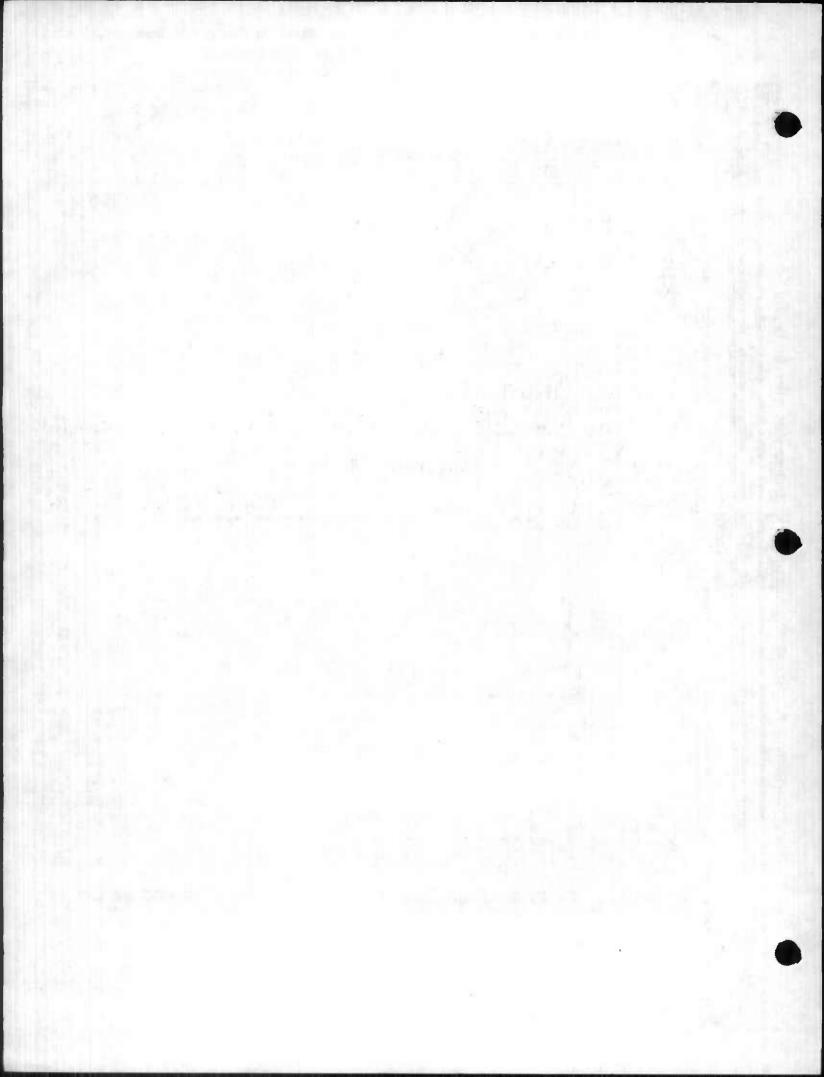
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State of Maryland / Department of Health and Mental Hygiene 00 26454

			Certificate of Dea	th Reg. No.	20404
	Dhunisian	Decedent's Neme (First, Middle, Last)		2. Date of Death	3. Time of Death
145	Physician /Medical	ERNEST DIG		AUGUST 17 2	1000 7:45 PM
	Examiner	4a Fecility Name (If not institution, give street and number, NORTHWEST HOSPITAL	CELLER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Death ORE.
	Funeral Director	5. Social Security Number, 6. Sex 7. A 1 M 2 F 7. A Usual Residence of Decedent	ge (In yrs. lest birthdey) If Under 1 Year If Un Months Deys Hou	rider 24 Hrs. 8. Date of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
	with the Maryland ta or 28a-f show to modified at	10a. State 10b. County	10c. City, Town or Location		10d. inside City Limits
	vith the Maryla t or 28a-f ahor be notified at Director	Maryland Baltimore	Woodlawn		1 Yes 2 No
	with the or 2 to 2 to 2 to 2 to 2 to 2 to 2 to 2	10e. Street and Number	TOTTO 00 2120	10g. Citizen of Wh	nat Country?
	fler death w r flems 23a fire m Funeral	11. Mental Status 12. Wes Decident Armed Forces	Ever in U,S. 13. Was Decedent of Hispanic if Yes, specify Cuban, Mex	Origin? (Specify Yes or No-	- American Indian,
0	by d	1 Never Married 2 Married 1 Yes, Give Year or Dates:	No 1 □ Yes 2 X No Speci		white, etc. - American
15-0	n 72 hours natural; or call b	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during r life. DO NOT use retired)	most of working	iness/Industry
7.	led within 72 ho ygjene. Ner than "naturi it, in Hodeal	Elementary/Secondary (0-12) College (1-4or	Representative t	o Council 11.S.C	overnment
	should be filed vand Mental Hygie i marked other ti umartic avant, to To Be Co	17. Father's Neme (First, Middle, Last)		other's Name (First, Middle, Maiden Sumame,)
Maryland	Ment Merked	George Grant	Diggs E	The Mildred	Frye
Mai	th and the modern of the moder	19a. Informant's Nache/Relationship (Type, Print)	oter) Jap Mailing Addrass (Street end Nu	umber or Rural Route Number, City or Town, S	tate, Zip Code) 21207
ore,	permit. Pages 1 and 2 should be filed with Department of Hatalt and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic avant, trail ands. To Be Comp	20a. Mathod of Disposition	20b. Place of Disposition (Name of cametery, cremetory or other place)	Date 20c. Location - C	ity or Town, State
aitimore	Page nent c ury or	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)	Greenmount Gene	atory 8/19/2000 Balt	o, Md.
Bait	permit. Pag Department Important: I any Injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Fa	acility / Funeral Hox	n P
	00540	Joseph J. K	WW 2222 W. NO	orth Ave. Balto. N	d.21216
	Physician	23a. Part I Enter the disasse, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not enter the mode of dying, sucr ine.	n as cardiac or respiratory arrest,	Approximata Interval Batween Onset and Death
461	/Medical	Immediate Cause (Final disease or condition	E MYDCARDIAL	INFARCTION	
	Examiner	resulting in death)	Due to (or as a consequence of):		
	executed and fal-transit	b			
o,	cate be executed physician and strensit the burial-transit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	Due to (or as a consequence of):		
68760,	5 5 5	Cause (Disease or Injury that initiated events resulting in deeth) Lest	Due to (or es e consequence of):		
	5 0 6 2	d.			
	The law requires that the death certifical also has been signed by the attending pt page 2 should be detached for use as it Completed by Physician/Med			one fild set	
0	by the tached	Part II. Other significant conditions contributing to death I			ribute to the cause of death? 3 Probably 4 Unknown
	igned by be detailed by Pt	CONGESTIVE (ARDIO	WAOLULY.		
	requires seen sign hould be	ansumonia.		24a. Was an autopsy performed?	24b. Wara autopsy findings svailable prior to completion of cause
Rec	The law to page 2 s			1 No. 1 No.	of death?
tai	ysician: The lavis certificate has director, page 2	25. Was casa rafarred to medical	26. P	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
>	Physician: this certific ral director, TO Be	examiner? 1 Yes 2 No Hospital: 1 Inpati	ent 2 ER/Outpatient 3 DOA Other: 4	Nursing Home 5 Residence 6 Othan	(Specify)
סע	When the uneral uneral lon:	27. Manner of Death 1 Natural 5 □ Pending (Month, December 1)	y Yeer) injury Work?	28d. Describe how injury occurre	d
Division of	tal or Attanding P is after death. al Director: After t led in by the funers Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of In	M 1 ☐ Yas 2 jury - At home, farm, street, factory, office	28f. Location (Street end Number	r or Rural Route Number,
S C	d in b	4 ☐ Homicide determined 296. Place of it building, e	c. (Specify)	City or Town, Steta)	
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1		of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion,		
	Vithin 2	29b. Signeture and fittle of cartifier	29c. License numb		(Month, Dey, Year)
	4	Hanny my.	7 4272		17TH 2000
	-20 ·	30. Name and address of person who completed cause of	death (Itam 23a) (Type, Print) NORTH	HORRISTON N	AL CENTER.
	1 1/3	AVYERAHALLI M 31 Dalenfiled-(MaethoDev Year) 32 Begist	HARISH R rar's Signature	MOTESTAVAR	ary 21133
	State	31. Date filed (Maging Day, Year) 32. Regist	al o Signaturo		

DHMH 16 Rev 6/95

ORIGINAL



Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 ahould be filed within 72 hours after death with the Marylan Department of Health and Mental Hyplens, important: If item 27 is manied other then "netural", or item 22s or 28s-f show withinty or other traumetic event, the Medical Examiner must be hollified at obosis.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

226		State of N	Maryland / D	Department of Certificate	f Health and I		iene	26455
1. Decedent's Nar	me (First, Middle,	Last)	THE YEAR			2. Date of Deat	h	3. Time of Death
James	Bı	candon	Durham	1		Month		Yeer 00 11:51 P.
		give street and numbe			4b. City, Town, or I	_AUGUST	4c. County o	of Deeth
TOHNS	HODKING	HOSPITAL			DATTI	ODE	N	/7
5. Social Security		S. Sex 7. /	Age (In yrs. last birt	hdey) If Under 1 Y	BALTTM ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, 11-02-	Veerl	Birthplace (State or Foreign Country)
219-04	-9398	X □M 2□ F	16	Yrs.	lys Hours Will.	11-02-	83	MD
Usual Residence	-		40-00-7	11				and trade on their
10a. Stete MD	10b. County NA		10c. City, Town					10d. Insida City Limits Xi Xi Yes 2 □ No
			54141					
10e. Street and Ni				10f. Zip Co		1	0g. Citizen of W	
	lary Ave				206		US	
11. Marital Statua		12. Wes Deceder Armed Force:	s?	13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuben, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, , White, etc.
	rried 2 Married	11 105, CIVE	No	1 Yes 2	No Specify:		Specify:	Black
3 Widowed		Year or Dates		Decedent's Usual O	aunation .		16h Kind of Rus	
	15. Decedent's ecify only highest	grade completed)			one during most of wor	king	16b. Kind of Bus	moormuustry
Elementary/Sec		College (1-4o	r 5+)	Student			Stude	ent
9th Gr		NA NA		Deadene	18. Mother's Nan	ne (First, Middle, A		
James		Durham	n		Pamela		Berry	
	Name/Retationship			Mailing Address (Si	reel end Number or Ru	ral Route Number	City or Town, S	Stete, Zip Code)
	sposition Congression Significant Significant Special		20b. Pleca of cemeter	Disposition (Neme of y, cremetory or other nmount Co	emetery 0	Date 8-24-20	20c. Location - 0	yland 21206 Dity or Town, State altimore, MD Tyland 21202
1/0	untl	Rul		WM.C.M	arch FH 1	101 E.	North	yland 21202 Avenue
Immediate Cause disease or condit resulting in death Sequentially list of if any, leading to cause. Enter Unc Cause (Disease of that Initiated even resulting to death	conditions, immediate derlying or lying	a	Due to (or as a c	consequence of):	ourdo	f Clo	est	
resulting In death	Last	Charles .						
		0	100					1
	ificant condition	contributing to death	but not resulting in	n the underlying caus	e given in Part I.	23b. Dld to	N	tribute to the cause of death 3 Probably 4 Unknow
						24a. Was a perform	in autopsy med?	24b. Were eutopsy findings eveilable prior to completion of cause of death?
The state of						XY	es 2 No	1 Yes 2□ No
25. Was case refe	erred to medical				26. Place of Dea	ath (Check only on	le)	
examiner?] No	Hospital:	itient 2/2 ER/Ou	tpatient 3 DOA	Other:	lome 5□ Reside		or (Specify)
27 Manner of Des	5 Pending Investiga	28a. Date of Ir	jyry 28b. T		Injury at Work? 1 Yes 201No	28d. Describe ho		
3 ☐ Suicide	6 ☐ Could no determin	ad 288/Placa of	Injury - At home, fa etc. (Specify)	rm, street, factory, of	fice	28f. Location (St City or Tow	reet end Number, Stete)	er or Aural Route Number,
1 Natural 2 Accident 3 Syicide 4 Comicide 29a. Certifier (Check only	2 Medical Ex		of examination and	d/or investigation, in		irred at the time, d	ate and place, e	and due to the cause(s)
29b. Signadaru un	d title of certifier	rles	B		cense number	2	9d. Dete signed	(Month, Dey, Year) 18,2900

JAN .

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
T—Wow W III P

AHE A A AAA

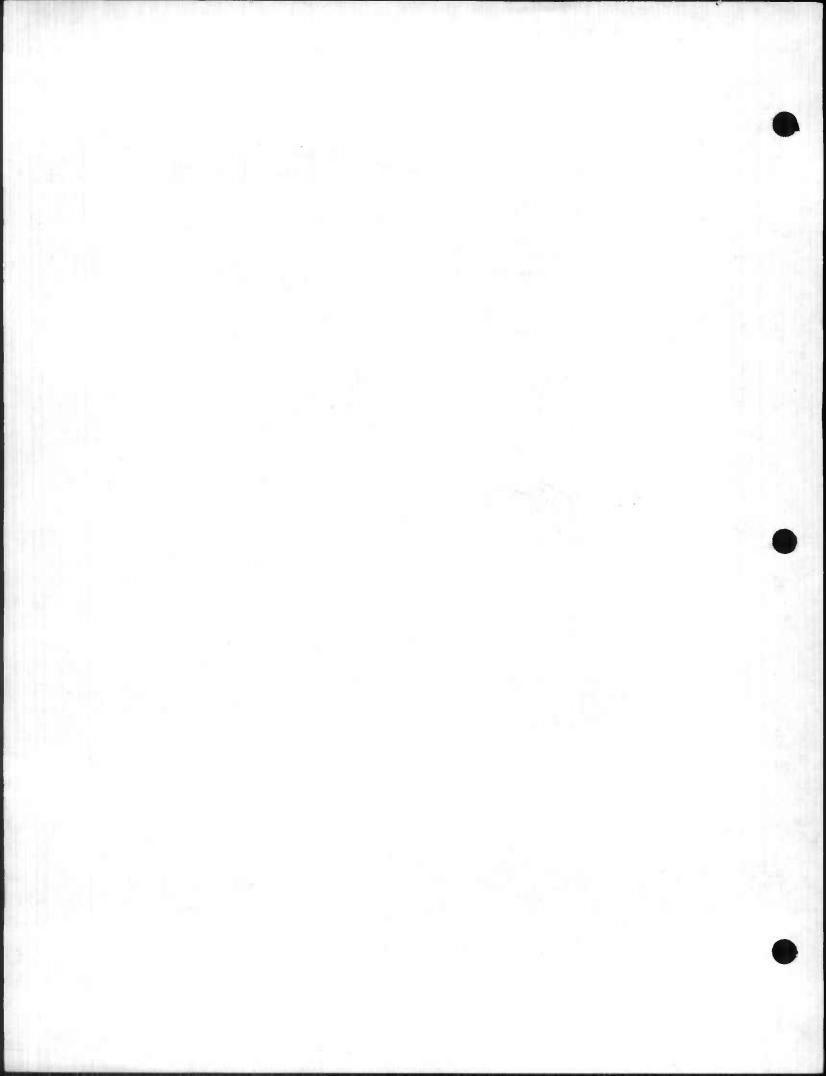
111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Month, Dey, Year)

AUG 2 2 2000

32. Registrar's Signature

Sparks



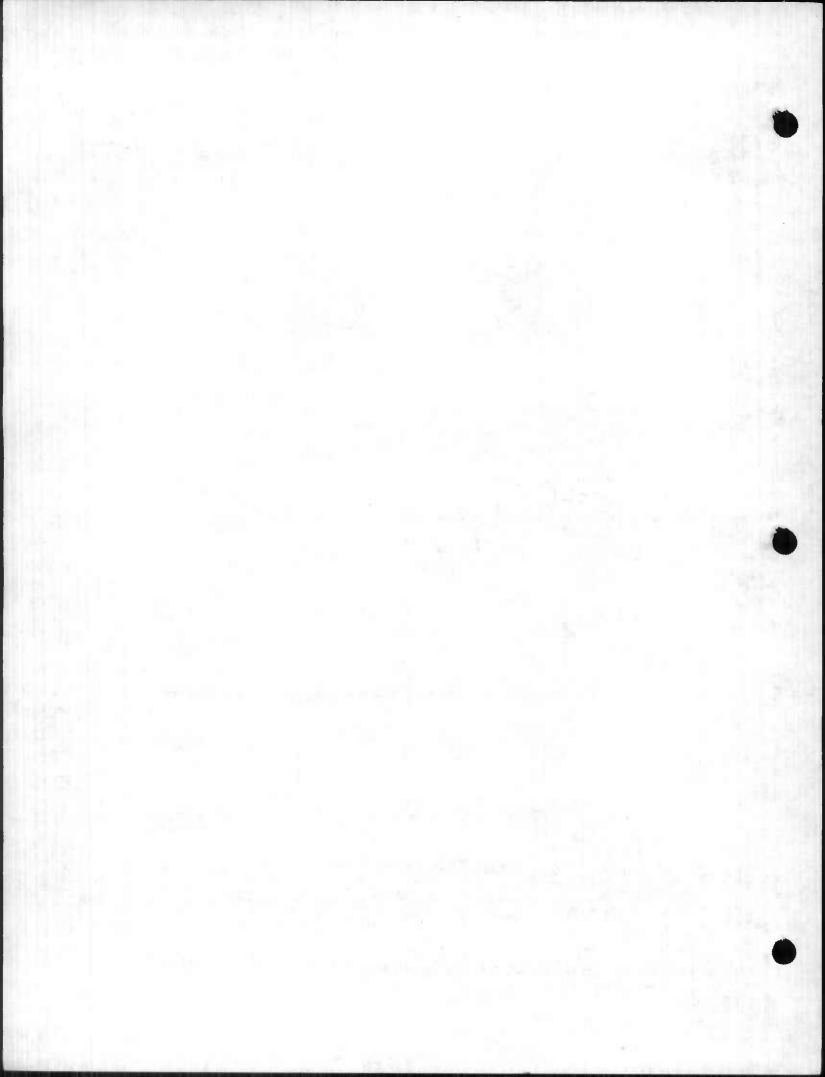
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State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		J. No.	6456	
	Physician	Decedent's Neme (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death	
4 7	/Medical	Wilbur Eugene Ensor, Sr.		19, 2000	6:33PM	
1	Examiner		or Location of Death	4c. County of Death		
- 1		14936 Tanyard Road Span 5 Speial Security Number 6 Sex 7 Age (In vrs. lest hirthday) If Under 1 Year If Under 24			imore	
	uneral rector		Hrs. 6. Dete of Birth (Month, Dey, Y	(ear) 9. Birth Cour 1930 Mar	place (Stete or Foreign htry) yland	
2	E es	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
Many	fled a	MD Baltimore Sparks			1 ☐ Yes 2 💆 No	
86	be notified Directo	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	ntry?	
9.6	at be	14936 Tanyard Road 21152		USA		
deat	E.m.	11. Menital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No-	s or No- ltc.) 14. Race - American Indian, Bleck, White, etc.		
21215-0020 d within 72 hours after giene.	Examin Liby Fu	1 Never Merried 2 Married 1 Yes 2 No If Yes 6 No If Yes 6 No Specify: Year or Dates:	gotto rinosi, otoly	Specify: Wh:		
25 25	t, the Medical Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16	b. Kind of Business/In	dustry	
121 dehin	und Idu	Elementary/Secondary (0-12) College (1-4or 5+)				
		12 N/A Dairy Farmer	Name (Sing Adiable Ada	Agricultu	re	
Maryland	B ed		Name (First, Middle, Ma			
Tyling I Me	thould marke marke		e Barbara E		Codel	
Ma	T is T					
Heat	other Star	20h Place of Disposition /Name of		c. Location - City or T		
timore Pages 1	dury or o	1 Buriel 2 Cremetion 3 Removal from Stete 4 Donation 5 Othar (Specify)	Butler, N			
Bal	any in	21. Signature of Funeral Service Us and Address of Facility Lemmon Funeral Ho 10 W. Padonia Roa	ome of Dular	ney Valley	Inc.	
		23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cer shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
/Me	sician edical miner	Immediate Cause (Final disease or condition resulting in death) e. Due to (or as a consequence of):	ein Gr	>	Onset and Death 2 / Coff	
68760,	nding physician and use as the burial-transit in/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
Box death cent	attending for use a		L con Blank		- 4	
	ed by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.		2 No 3 Pro	o the cause of death?	
	y PI			20 NO 30 FIG	only of onknown	
Records,	sale has been signed by the attending page 2 should be detached for use Completed by Physician/N		24a. Was an performe	ed?	fere autopsy findings vailable prior to empletion of cause death?	
	page 2		1 □ Yes	2189-No 1	□ Yes 200 No	
tal	rector, page Co	25. Was case referred to medical 26. Place of	Death (Check only one)			
	l director.	examiner? A Hospital: Other:	ng Home 52 Residen		fy)	
0 6	2 3	27. Manner of Death 127. Natural 5 Panding 28a. Date of Injury 28b. Time of Injury 4 Work?	28d. Describe how	injury occurred		
Division if or Attending after death.	y the fu	2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et end Number or Rur	el Route Number,	
Div	d in t	4 Homicide building, etc. (Specify)	City or Town,	State)		
DIVISIO To the Hospital or Attendit within 24 hours after death.	Tuneral Director: Attent pletely lilled in by the funeral edical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my newbodge down occurred at the time, date and p 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of an opinion of the control of t	lace, and due to the cau occurred at the time, dat	se(s) and manner as e and place, and due	stated to the cause(s)	
To th	Memp	29b. Signature end title of cartifler 29c. License number	290	d. Date signed (Month	Day, Year)	
	1	1/1/1/1/22	36	4-21	-2000	
00	4(1)	30. Name and address of porson who completed sausa produkte (from 23a) (Type, Print)		U - U/	2000	
0	(Ayman F. Akkad, MD 7600 Osler Dr. Suite 411 Towson	n, MD 21204			
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature Sparks				
F	Registrar	AUG 2 2 2000				

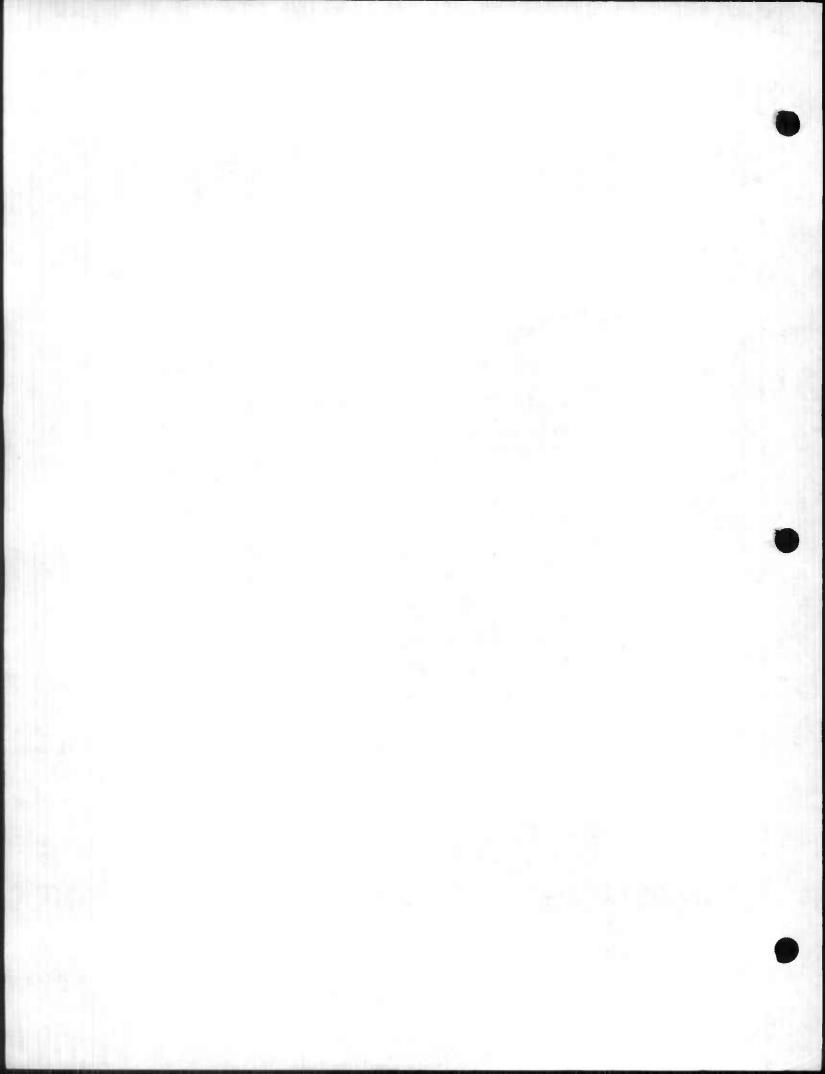
ORIGINAL

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent'a Name (First, Middle, La	of)	C	ertificate of	Death	2. Dete of De	Reg. No.	3. Time of Death	
Physician			1			Month	Dey	Year Jacon	
/Medical		IA FISH	1		4b. City, Town, or	AU GUST			
Examiner	4a Facility Name (If not institution, giv		CALTED						
	HARBOR HO 5. Social Security Number 6. S		n yrs. last birthda	If Under 1 Year	BALT (A		n/a	Birthplace (State or Foreign	
Funeral Director		OM 283 F 7.2	Van	Months Deys			y. Year) , 1924	Country) Maryland	
ahow d.ml	10a. State 10b. County	10	Oc. City, Town or	Location				10d. Inside City Limits	
oto	Maryland Baltimo	re	Baltim						
a or 28a-f show be notified at Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
四 声	2618 Tulip Avenue				227		U.S.A.	- American Indian,	
st, or items Examiner m by Funer	11. Marital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	or in 0,5.	3. Wes Decedent of I If Yes, apecify Cub 1 ☐ Yes 2 ☑ No		to Rican, etc.)	Specify:	k, White, etc.	
ted ted	15. Decedent's Ed	ducation	16a. De	cedent'a Usual Occup ve kind of work done	pation	dina	16b. Kind of Bus	siness/Industry	
t, the Medical Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use retire	during most or wo	rking			
att o	12		Scho	ol Bus Dr	iver		Baltimo	re County Sch.	
9 9	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Sumame	9)	
To E	John Ripley				Viola N	Aae Souder ural Route Number, City or Town, State, Zip Code)			
and a	19a. Informent's Name/Reletionship (-						
other tra	Edward H. Fish /			8 Tulip A	venue, Ba				
	20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other piece) 20c. Location - City or cemetery, crematory or other piece)								
20	4 Donation 5 Other (Specif		y, Inc.	8/23/20	00 Balti	more, Maryland			
E a	21. Signatore of Funeral Servica Licer	1500		22. Name and Addre	ess of Facility				
1 2 3	DAWY RO	Comme		Hubbard				. 1 1 0100	
	23a. Part Linter the disease, or com shock, or heert failure. List only	nlications that caused the	a death Do not	41U / W11	kens Avei	or respiratory a	cimore,	Maryland 2122	
edical miner	Immediate Cause (Final disease or condition rasulting in death)	a	e to (or as a cons	OCARDIA sequence of):	IL PNF	ARCTIC	N	15-30 m	
s the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Du	e to (or as a cons	sequence of):				11/19076	
-	Cause (Disease or injury that initiated events resulting in death) Last	d.	e to (or as a cons	equence of):		100			
for u								1	
tached the short of the short o	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the	resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribution					
d by Physician/M	PNEUMONIA	, DIAB	ETES,			1 🗆	Yes 2□No	3 Probably 4 ☐ Unknow	
hould	CONGESTIVE	HEART	FAIL	URE -			an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
s certificate has t director, page 2 s o Be Compli						10	Yea 2 No	1□Yea 2⊡No	
director,	25. Wes case referred to medicel examiner?				26. Place of De	ath (Check only	one)		
	1 Yes 2 No	Hospital:	2 ER/Outpat	ient 3 DOA	her: 4 Nursing I	Home 5 Res	idence 6 Othe	er (Specity)	
= 0	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Y	98r) 28b. Time Injur	y Wo	ryat ork?]Yes 2 □ No	28d. Describe	28d. Describe how injury occurred		
To the Funeral Director: Affer thi completely filled in by the funeral Medical Certification: 1	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Pleca of Injury building, etc. (- At home, farm, Specify)	atreet, fectory, office	13.71	28f. Location (City or To		er or Rural Route Number,	
pletely fill.	29a. Certifier 1 Certifying Ph (Check only cone) 2 Medical Exam	ysician: To the best of n niner: On the basis of ex end manner atated	aminetion and/or	ath occurred at the t investigation, in my	ime, date and place opinion, deeth occ	a, and due to the urred at the time,	cause(s) and mai date and placa, a	nner as atated. and due to the cause(s)	
Ne	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	(Month, Dey, Year)	
20) ans		199711		Augus	it 19,2000			
5	30. Name and eddress of person who	completed cause of deat		e, Print) TH HAN	lover	ST. BA	LTIMOR	RE. MD 2122	
State	31. Date filed (Month, Day, Year)	2000 32. Registrar	Signature	4 /	a Va				



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			State of Maniford /	Department of Health and I	Aental Hygiene	001 00
unknown	00-218 AMEND TITEMS	. #23	Dyfale hi Marhianay	Department of Health and N FF PER MEO C786 8-24- Certificate of Death	Mental Hygiene	76151
Chamban	Co 210 AMEND TITLE	· #23	TAKE 1, 21, 20A	-F PER MEU G 100 0-24-	OU WR.	と し ず し い
Stephen	Scott Ferguson			Certificate of Death	Reg. No.	

Physician	AMEND ITEM Ferguson 1. Decedent's Nema (File STEPHEN)	rst, Middle, L	ast)	ERGUSO			14 19		2. Dete of De Month	Day	Yaer	3. Tima of E	
/Medical	4a Facility Nama (If not							4b. City, Town, or L	ocation of Deat		_2000 inty of Deal		pm
Examiner	452 East 2				r Ant			Baltim		N/A			
uneral rector	5. Social Security Numb 219-82-1260	er 6.		7. Age (In yrs. 42	- de	If Under Months	1 Year Deys		8. Date of Bir (Month, De August 2	rth ey, Year)	9. Birt	thplace (State or buntry)	Foreig
COTO	Usuel Residence of Dec	edent		72		rugust 2, 1700 Intry it					yland		
No.	10a. Slete 10t	o. County		10c. Ci	ty, Town or Lo	ocation						10d. inside City	/ Limits
23a or 28a-f ahow and be notified at rej.Director	Maryland	N/A		Ba	1timor	e				11 Yes 2 □ P			2 No
23a or 28a-f	10e. Street and Number					10f. Zip	Code			10g. Citizen of What Country?			
3	20 MacBeth	Drive			21239			4 4 4	U.	S.A.			
Funer	11. Marital Stetus		12. Wes Dece	dent Ever in U	J.S. 13. Wes Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,					0- 14. [ncan Indian,	
y Fune	1 Never Married	2 Married	Armed For	2 🔯 No					Hican, atc.)		Black, Whit	e, etc.	
m - D	3 ☐ Widowed 4 ☐	Divorced	If Yea, Giv Year or De	e otes:	111111	1 ☐ Yes 2 🕅 No Specify: Specify:					B1	Black	
rdical Ex	15.	Decedent's E	ducation		16a. Dece	dent's Usua	t's Usuel Occupation d of work done during most of working NOT use retired)					Industry	
p pie	Elementery/Secondar		rade completed) College (1	-4or 5+)	life.	DO NOT u	se retired	d)	ung.				
E 2 0	12 years	3			Speci	ialty	Adj	uster		Envelo	pe Ma	nufactu	rin
	17. Fathar'a Name (First	t, Middle, Las	1)					18. Mother's Nam	a (First, Middle	, Meiden Sun	name)		
9 0	Calvin		Fergus	on				Bertha		J	ohnso	n	
une.	19a. Informent's Neme/	Reletionship	(Type, Print)		19b. Maili	ng Address	(Street	end Number or Rui	rel Route Numb	per, City or To	wn, Stete, a	Zip Code)	
-	Teresa Bost	con			6120) Macl	Beth	Drive Ba	ltimore	e, Mary	land	21239	
de la	20e. Method of Disposition				Pleca of Dispo cemetery, cre	osition (Ner	ne of ther plea	ce)	Date	20c. Location	on - City or	Town, State	
ry or	1 ☐ Burial 2 XXCremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify)									timor	e, Maryl	Land	
any Injury o	21. Signeture of Funere	Service Lice	ensee		2:	2. Neme er	d Addre	ess of Fecility					
oud oud	D.C.	1	E		M	itche	11-1	Wiedefeld	Funera	1 Home	, Inc	01010	
	23a. Pert1. Enter the di shock, or heart fail	eesa, or cor	nplications that co	aused tha daa	th. Do not en	ter tha mod	YOTK e of dyir	k Road B	or respiretory a	e, Mar	yrand	Approximete	
ian	shock, or heart fail	lure. List only	y one cause on e	ech line.								Interval Betw Onset end De	een
ical	Immediata Cause (Fina	1		ACUT	E NARC	OTIC	INTO	OXICATION					
ner	disease or condition resulting in death)		a										
ē				Due to (or es e conse	quence of):							
Examiner			b	Dun to 1		nuones an							
i Exan	Sequentially list condition if any, leeding to immediate. Enter Underlying	ons, liate		Duis to (or es e conse	quenca of):							
5	Cause (Disease or Injury	4	C	Dun to fe									
edical	resulting in death) Last			Due to (d	or as a consac	quanca or):							
for use as t			d										
for for	Dodli Other India	h a a a added : .		and beautiful	teles to the	on dead to		and Decide	por pr	l de bassa su su su su su su su su su su su su su		to the course	i ala-as
70	Part II. Other significant	conditions	contributing to de	EUT DUT NOT 105	suiting in the u	maerrying o	ause giv	van in Part I.				to the cause of	
nysic									10	T0\$ 2□ N	10 3 P	robably 4	MINION
Phys													
2 2				1119					24a. Was	s en autobsv	24b.	Were sutopsy fir	ndings
b 8 8									24a. Wes	s en autopsy ormed?		Were sutopsy fir available prior to completion of ca)
									24a. Wes	s en autopsy omed?		available prior to	usa

To the Hospital or Attending Physicie within 24 hours after deeth.

To the Funeral Director: After this certi completely filled in by the funeral direct Division of Vi Medical Certification: To

axaminar? 15 Yes 2□ No 27. Manner of Death

5 Pending Invastigation 6 Could not be determined

28a. Dete of Injury Found: Dey Year) 8–15–00 28e. Plece of Injury - At home, farm, streat, fectory, office building, etc. (Specify)

Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of Found.

Other: 4 Nursing Home 5 Residence 6 Tother (Specify) at scene 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

UNKNOWN

281. Location (Street and Number of Eurol Royle Number City or Town, State) 452 E. 28TH ST., 2ND FL. BALTIMORE, MD

29e. Certifier (Check only one)

1 Neturel

2 Accident

3 Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steled.

FOUND AT HOME

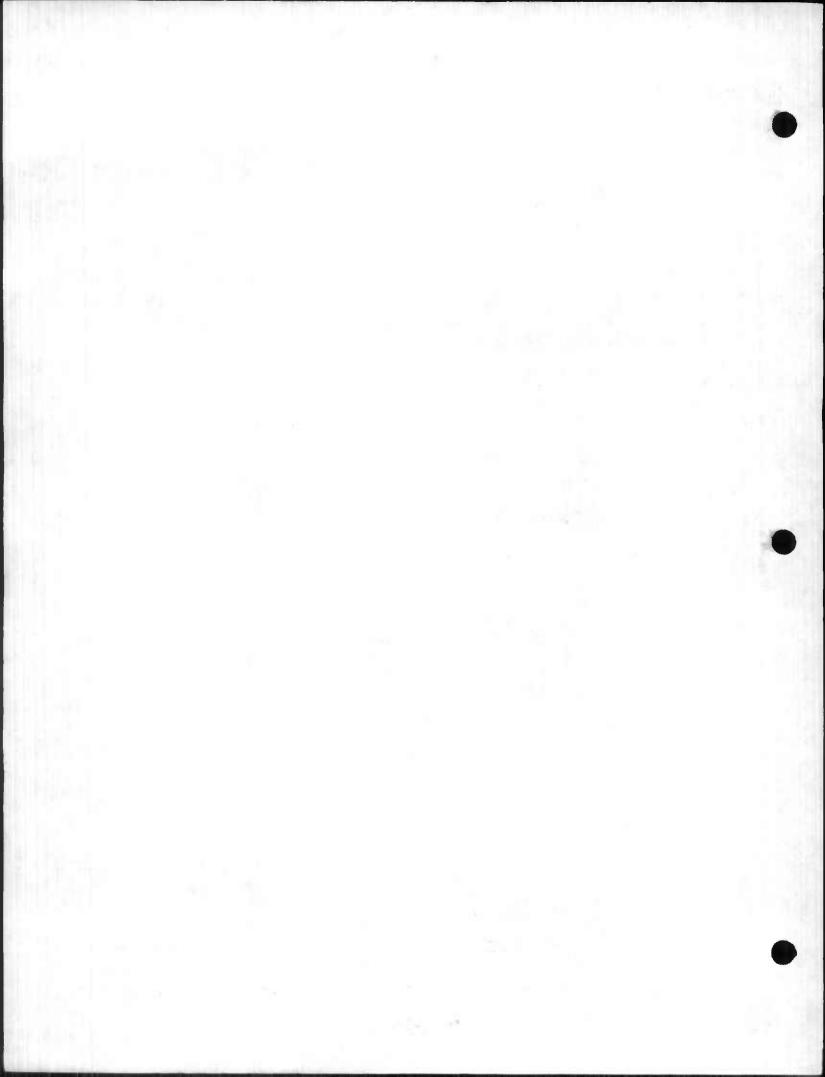
29b. Signeture and title of certifier

29c. Licansa number O.C.M.E. 29d. Date signed (Month, Day, Year) August 16, 2000

30. Nema and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

Pennis Chute, M. D. 111 Pe Dennis C 31. Date filed (Month, Day, Year) Aug 2 2 2000 111 Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Year **Aonth** 6:40 P.M. William H. Gelston HUgust 20 2000 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth N/A Union Memorial Hospital Baltimore If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthdey). 75 Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Dec. 11. 1924 6 Sex 9. Birthplace (State or Foreign 219-16-4869 XIXM 2DF Months Deys Hours Illinois Usual Residence of Decedent 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 N Yes 2 No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3663 Keystone Avenue 21211 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ♥ Yes 2 □ No If Yes, Give Yeer or Detes:WWII Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 X Married 1 Yes 3₽No Specify: Specify: White 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Night Watchman Security Unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Hugh D. Gelston Elsie A. Stringer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21211 19e. Informent's Neme/Reletionship (Type, Print) George Gowe Brother-in-law3663 Keystone Avenue, Naltimore, Maryland 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetery or other piece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetlon 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 8/25/00 Beltsville, MD 21. Signeture of Sunerel Service Licensee 22. Name end Address of Fecility Burgee-Henss-Seitz Funeral Home, 3631 Falls Road, Baltimore, Maryland 23e. Pert1. Enter Je disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hard feilure. List only one cause on each line. Approximete Interval Between Onsel and Deeth Immediate Cause (Final sepsis 24 hours diseese or condition resulting in death) Due to (or es e consequence of): respiratory failure Zhours Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): hyperkalemia Z4hours Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? 1 Yes 2 Divo 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Yes 2 No

The law requires that the death certificate be executed pue Box 68760 physiclen the ettending p P.0. the s been signed by t 2 should be detach Records, page 2 s certificate Division of Vital al or Attending Physicien: The safter death.

I Director: After this certificated in by the funeral director, pages.

Examiner Physician/Medical þ Completed Be P Certification: To the Hospital pletely filled edicai

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ò

or items 23a

"natural".

Hygiene.

marked other afth end Mental Hve 7 is mark-

permit. Peges 1 and 2 s Department of Health er Important: if item 27 is any Injury or other trau

Physician /Medical

Examiner

the

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

the Medical Examiner neat be notified at

Director

Funeral

by

Completed

Be

1 Yes 2 No 27. Menner of Deeth 1 Naturel 2 Accident

4 Homicide 29a. Certifier (Check only one)

3 Suicide

6 Could not be determined

5 Pending Investigation

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier

29c. License number AU4176435L

29d. Dete signed (Month, Dey, Year) August 20, 2000

Location (Street end Number or Rural Route Number, City or Town, State)

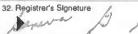
30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

TOM LINBERG MD 31. Dete filed (Month, Dey, Year)

memorial Hospitm, BACTIMIZE, MARYLAND Union

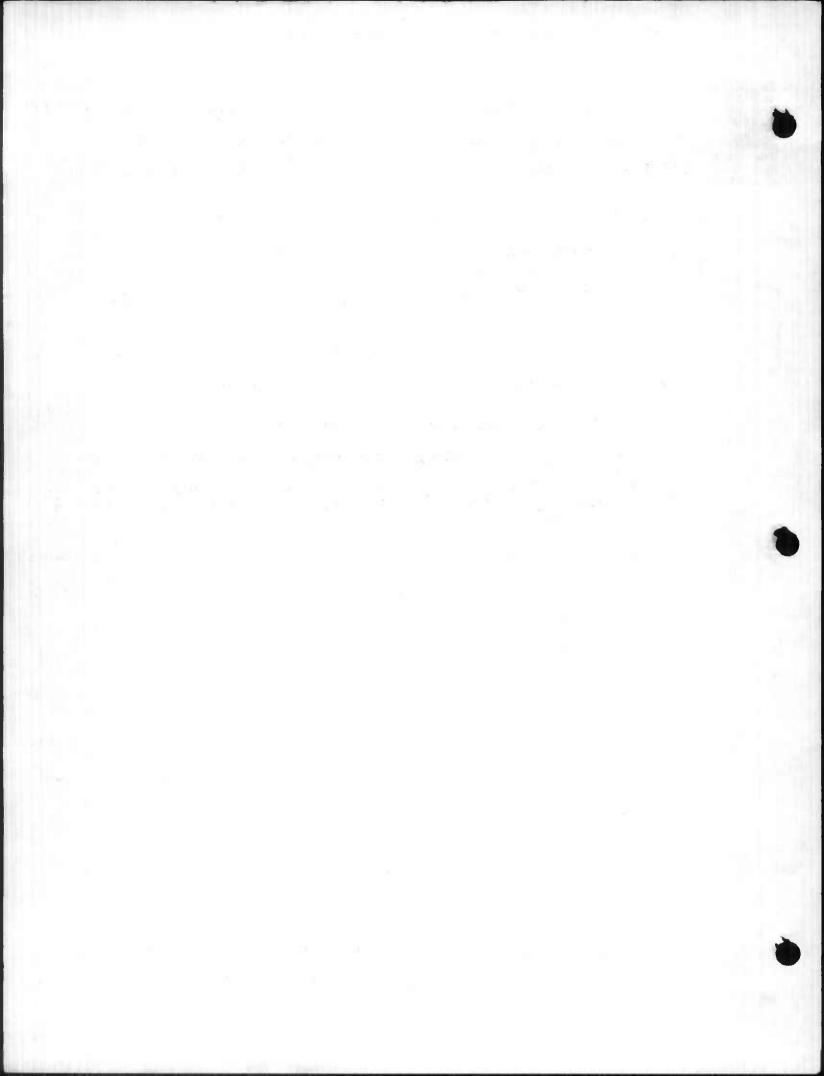
State Registrar

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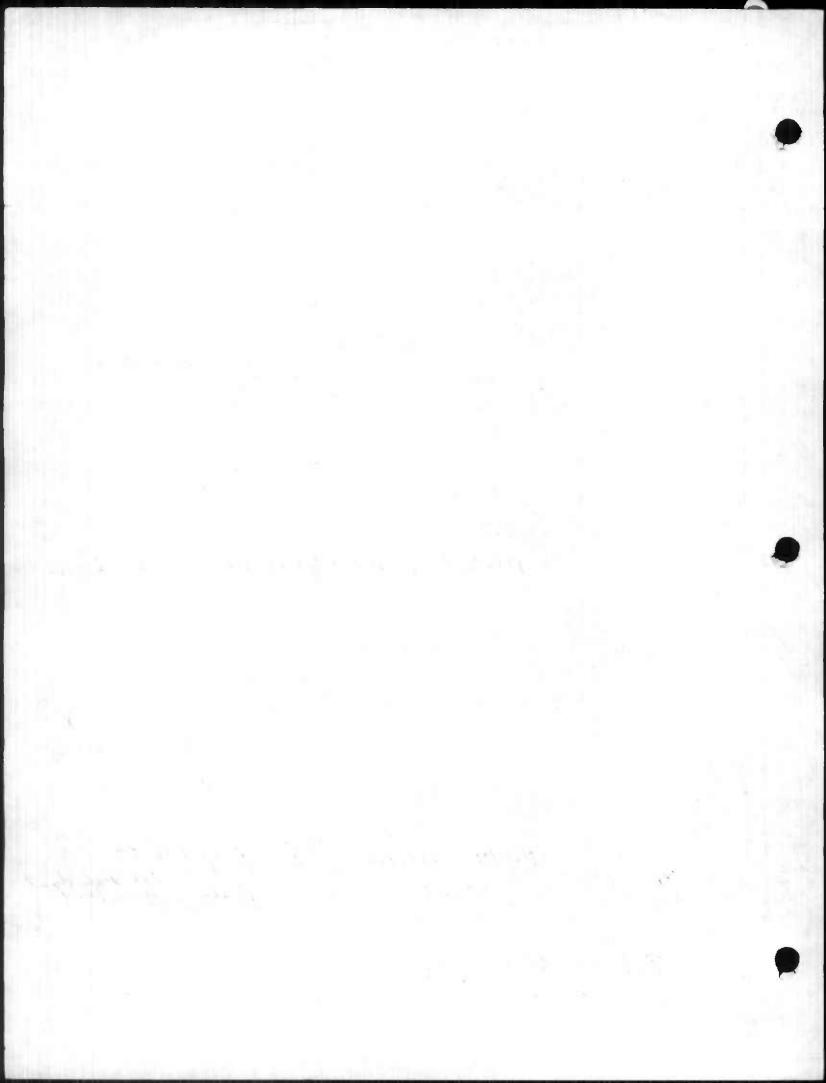


Please Type or Print In Black Indelible ink. Assure All Copies Are Legibie.

		Decedent's Name (First, Middle, Last)	1	Cei	rtificate of	Death	2. Date of De	Reg. No.	3	Time of Deeth
	sician edical	Daniel Eugene Ga					AUGUS			1007 PM
	miner	4a Facility Name (If not institution, give : SHOCK TRAUMA	street and number)			4b. City, Town, or Li BALTIMOR		4c. County	of Death	
Funer Direct	_	414-00-5798	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De Oct.	Birth 9. Birthplaca (State or Fore Country) 27, 1962Md.		Stete or Foreign
yland		Usual Residence of Decedent 10a. Stata 10b. County Md. Anne An		City, Town or Lo						
he Ma	Director	10e. Street and Number	nder		10f. Zip Code	Linthicum		40a Citizan of la		□ Yas 2 XXo
3a or	JO IS	6530 Harrison Ave	nue		210	90	Second 1	USA	3. Tima of Deeth 1007 PM Country of Death n/a 9. Birthplaca (Stete or Foreign Country) 1962Md. 10d. Inside City Limits 1 Yas 2 Xivo izan of What Country? JSA 14. Race - Amarican Indian, Black, White, etc. Specify: Black ind of Business/Industry Sumame) or Town, Stete, Zip Code) Reights, Md. 21090 Docation - City or Town, State Kridge, Md. L Homes, Inc. Ore, Md. 21216 Approximate Interval Between Onset and Death Onset and Death Death Onset and Death Onset and Death Approximate Interval Between Onset and Death Onset and Death	
72 hours after deeth with the Maryland 72 hours after deeth with the Maryland 7 antural, or frema 23a or 28a-f ahow attal Earning man be routed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedant Evar in Armed Forces? 1 Yes 2 No If Yas, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Maxican, Puerto Specify:	ecity Yes or No Rican, etc.)	Blac	k, White, etc.	
	Completed	15. Decedent's Edu (Specify only highast grade		(Give	DO NOT use retire	during most of work d)	ing	0	7,	
to the the	Be	Nathaniel Gales Jr. Nathaniel Gales Jr. Mary Dai								
nd 2 lith e	-	19a. Informant's Neme/Relationship (Type, Print) Mary Gales 19b. Mailing Address (Street end Number or Rural Route Number, City of 6530 Harrison Avenue Linthicum H								21090
permit. Pages 1 e Department of Hee Important: If item any injury or othe		20a. Method of Disposition **X**Burial 2 Cramation 3 R 4 Donation 5 Other (Specify)	removal from State	Meadowri	osition (Name of metory or other pla idge Ceme	tery A	ug. 24	Elkride	ge, Md.	
Physicial / Medic Examine Deposition and Deposition and as the puriar-linearity as the puriar-linearity as the puriar-linearity as the puriar-linearity as the puriar-linearity as the puriar-linearity and the puriar-linear	al er e	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due t	to (or as a consection of the consection)	colot (quence of):			.//		
n certificate anding phy use as the	-	resulting in death) Last	Dua	o (or as a consec						
death e atte	hys		1.		quance of):					
. 0 0 %	hys	Part li. Other significant conditions con		rasulting in the u		ven in Part I.		tobacco uee cor Yee 2□ No		11
w requires that the d	oleted by Physi			rasulting in the u		ven in Part I.	1 □ 24a. Was peri	Yee 2□ No s an autopsy ormed?	3 Probably 24b. Were a svailabl comple of death	utopsy findings e prior to tion of causa
The lew requires that the date has been signed by the page 2 should be detached	oleted by Physi	Part li. Other significant conditions con 25. Wes case referred to medical	ntributing to death but not	rasulting in the u	underlying cause gi	26. Plece of Dee	1 24a. Was peri	Yee 2□ No san autopsy ormed? Yes 2□ No	3 Probably 24b. Were a svailabl comple of death	utopsy findings e prior to tion of causa
yalclan: The lew requires that the d is cartificate has been signed by the director, page 2 should be detached	To Be Completed by Physi	Part li. Other significant conditions con 25. Wes case referred to medical	ntributing to death but not	2 ☐ ER/Outpatie	underlying cause gi	26. Plece of Dee her: 4□ Nursing H	24a. Was peri	Yes 2 No	3 Probably 24b. Were a svaliable comple of death 1 Yer	Unknow utopsy findings e prior to tion of causa
yalclan: The lew requires that the d is cartificate has been signed by the director, page 2 should be detached	To Be Completed by Physi	25. Wes case referred to medical exeminer? 27. Menner of Death 1 Naturel 5 Pending invastigation	ntributing to death but not	2 ☐ ER/Outpatie	underlying cause gi	26. Plece of Dee her: 4□ Nursing H	24a. Was peri	Yes 2 No Yes 2 No One)	3 Probably 24b. Were a svaliable comple of death 1 Yer	Unknow utopsy findings e prior to tion of causa
yalclan: The lew requires that the d is cartificate has been signed by the director, page 2 should be detached	To Be Completed by Physi	Part II. Other significant conditions conditions conditions conditions conditions conditions. 25. Wes case referred to medical exeminer? Yes 2 No	dospitel: 1 Suppatient 28a. Date of Injury (Month, Pay Yea 9 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2 ER/Outpatier r) 28b. Time of Injury 2 2 3 5 At home, farm, st	anderlying cause gi	26. Plece of Dee her: 4□ Nursing H ny at rk?) Yes 2 No	24a. Was peri	Yes 2 No No No No No No No No No No	3 Probably 24b. Were a svaliable comple of dealt 1 Ver er (Specify) red	untopsy findings e prior to tion of causa 17
The lew requires that the date has been signed by the page 2 should be detached	To Be Completed by Physi	Part Ii. Other significant conditions condit	Hospitel: 1 The patient 28a. Date of Injury	2 ER/Outpatien r) 28b. Time of Injury 2 2 5 5 At home, farm, stepity)	anderlying cause gi	26. Plece of Dee her: 4□ Nursing H ry at rk? 1 Yes 2 No me, dete and placa.	24a. Wa: peri	Yes 2 No Yes 2 No One) idenca 6 Oth how injury occur (Street and Numb wm, State)	3 Probably 24b. Were a svaliable comple of death 1 Ver er (Specify) red anner as shaled	utopsy findings e prior to tion of causa 17

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Ducedonf's Nama (First, Middle, Last) 2. Data of Death 3. Time of Deeth **Physician** 3:18 Am August-2000 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Nama (If not institution, giva street and number) Examiner 9 ra more If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth **Funeral** Months Days Hours 49-34-9704 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stata 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a4 shon any injury or other treumatic event, the Mexical Exercises man by notified any injury or other treumatic event, the Mexical Exercises man by notified as 1 Yas 2 No Funeral Director Varyland mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 TOUR 14. Race - Amarican Indian, 12. Was Decedenf Ever in U,S. Armed Forcas? 1 ★ Yes 2 ☐ No If Yes, Give Year or Datas: 11. Marital Stafus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, afc.) Black, White, atc. 1 Nevar Married 2 Married 1□ Yes 2No Maryland 21215-0020 Aspecity: Specify by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 10 ar 19a. Informant's Name/Reletionship (Type, Print) (SISTER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Georgia Ve TO Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) , Data 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Son 101 est 22. Name and Address of Facility 21. Sig re of Funeral Service Lic nera 23a Pan Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, not, or heart felipre. List only one cause on each line. . 212 Approximate interval Between Onset and Death Physician /Medical Immediate Cause (Final nellmonia disease or condition resulting in death) Examiner Due to (or as a consequenca of): Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) use es the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 d Unknown been signed by 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? page 2 2 No 1 Yes 1 ☐ Yas 2 ☐ No

The law requires that the death certificate be executed Division of Vital Records, P.O. the Hospital or Attending Physician: this After death. filled in by the f

Medical Certification: To within 24 hours Registrar

funerel director.

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated December 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ver: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titte of certifie

Other:

1 Yes

2 No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A HMED 821 N. Ecul a

STREET Baltimore N. Eulaw

26. Place of Death (Check only one)

4 Nursing Homa 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

31. Data filed (Month, Day, Year)

25. Was case raferred to medical axaminer?

5 Pending

investigation

6 Could not be

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicida

29a. Certifier

4 ☐ Homicide

(Check only one)

32. Registrar's Signatura

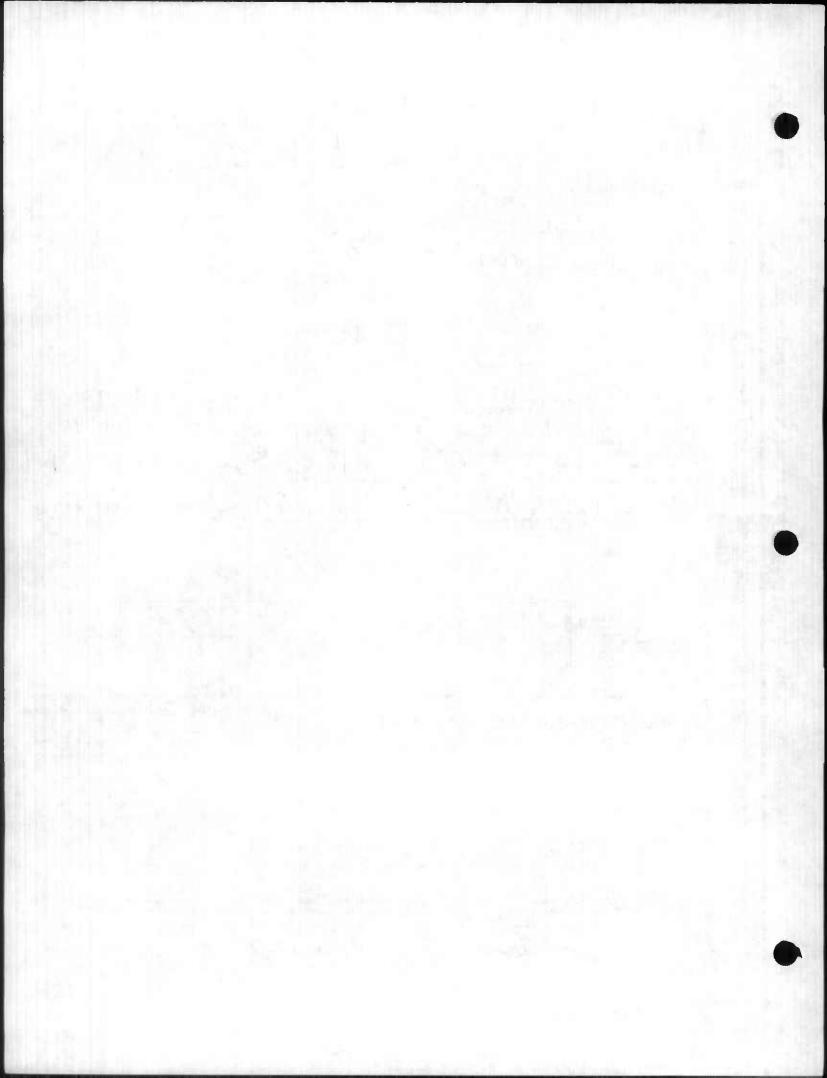
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28a. Dete of Injury (Month, Dey Year)

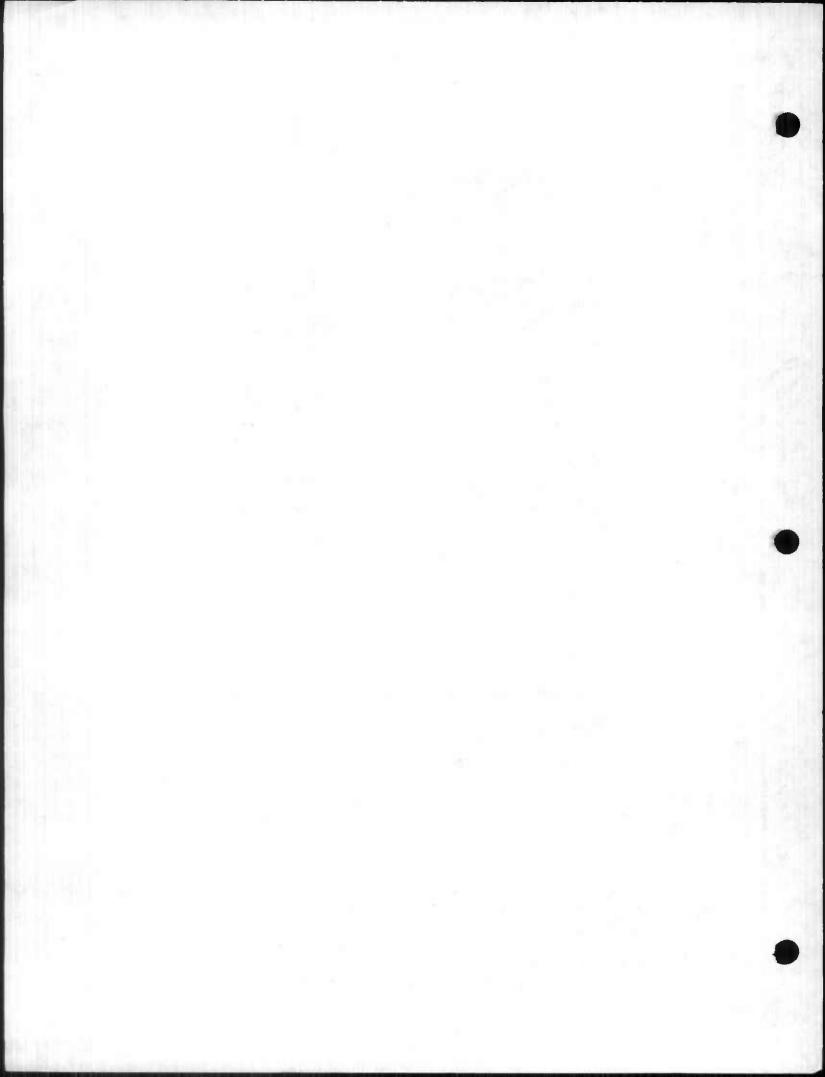
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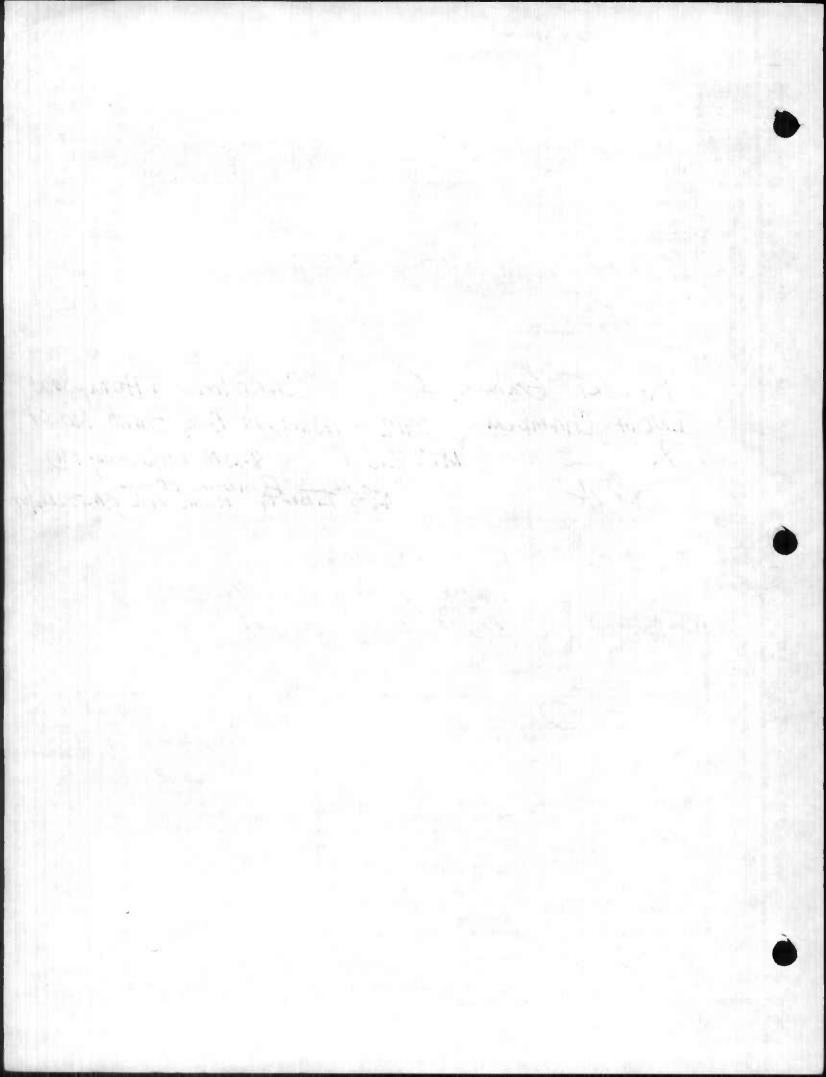
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg	, No.	0 26462				
	1. Decedent's Neme (First, Middle, Las	0()		100	2. Date of Death Month	Dey	3. Time of Death				
Physician /Medical	Annie Bell	l Green				200					
Examiner	4s Facility Name (If not institution, give	street end number)		4b. City, Town, or L	ocation of Death	4c. County of	of Death				
	Riverview Nurs	sing Home		Essex		Balt:					
Funeral Director	5. Sociel Security Number 6. Sociel Security Number 1. Sociel Security	9X 7. Age (In yrs. le	est birthdey) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Y 10-02-	(ear)	Birthpleca (State or Foreign Country) NC				
9	Usual Residence of Decedent	T. a.					1				
al day	10a. Stete 10b. County		, Town or Location				10d. Inside City Limit				
isr death with the Marylar here 33a or 28e+ show ner must be notified at 'uneral Director	MD NA	Ba	ltimore								
or 2	10e. Street and Number		10f. Zip Code		100	. Citizen of W	het Country?				
23a 23a	1416 May Cour	t —	2123	1		USA	Service Co.				
ther death there are 23 siner must Funeral	11. Marital Status	12. Wes Decedent Ever in U,S Armed Forces?	S. 13. Wes Decedent of If Yes, specify Cu	Hispanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-		- American Indian, , White, etc.				
		1 ☐ Yes X ☐ No If Yes, Give Year or Dates:	1□Yes 2☑No			Specify:	Black				
21213-0 ad within 72 ho opiena er than 'naturn er than 'naturn t, the Medical.	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usuel Occu (Give kind of work done	petion	ring 16	b. Kind of Bu	siness/Industry				
Man and	Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO NOT use retir	ed)							
N N S S S S S S S S S S S S S S S S S S	3rd. Grade	NA	Laborer				us trades				
Be doth	17. Father's Neme (First, Middle, Last)				e (First, Middle, Ma						
Via Mani Mani Mani To	Josh	Winstead		Lizzie	W	instea	ad				
Maryland 21215-0020 d2 should be liled within 72 hours at the and Mantal Hygiere. T is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	19a. Informent's Neme/Reletionship (7) Frances Bro		19b. Meiling Address (Street 1416 May C								
the Ham	20a. Method of Disposition	20b. Ple	eca of Disposition (Name of				City or Town, State				
mill. Pages 1 partment of He portant: if hen y Injury or oth	X\Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	. Zion Ceme		17-2000	Lans	sdowne, MD				
Deaml Depart Impoort any inj ansa	21. Signature of Euneral Service Licensee 22. Neme end Address of Fecility Baltimore, Marylan WM.C.March FH 1101 E. North Ave										
	23a Part1. Enter the disee of court shock, or heart feilure. List only	olications that caused the death					Approximete fntervel Between				
/Medical Examiner Examiner Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	Due to (or	es e consequenca of):	Denie	nara	- 7					
requires that the death certificate be executed requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the buriel-transit eted by Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last	c Due to (or	as a consequence of):		M						
ath certification and certific		d									
dS, r.O. box iries that the death cert signed by the attendin d be detached for use. d by Physiclan/M	Part fl. Other significant conditions co	ontributing to death but not resu	iting in the underlying cause of	iven in Pert I.		23b. Did tobacco use contribute to the cause of death					
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The law requires the law requires the last been signed page 2 should be completed by					24a. Wes en performi	eutopsy ed?	24b. Were sutopsy findings svailable prior to completion of cause of death?				
The law are has be page 2 s					4534	2 D No					
	OF Miles again referred to made at			00.5	1 Yes		1 Yes 2 No				
OT VITAL ME Physician: The larthis certificate he rail director, page	25. Wes case referred to medical examiner?	Hospitel:		then	th (Check only one		10				
0 5 5 6	1 Yes 2 No	1 Inpatient 2 L	EPVOutpatient 3LI DOA	4 Mursing n	ome 5 Residen						
nding Path. w: After	1 Neturel 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury W	ork? Yes 2 No	28d. Describe nov	vinjury occurr	90				
DIVISION OF VITAL tal or Attending Physician: T as after death. al Director: After this certificat ided in by the funeral director, po	3 Suicide 6 Could not be determined	28e. Plece of fnjury - At hor building, etc. (Specify,	me, ferm, street, fectory, office	9	28f. Location (Stre City or Town,		er or Rural Route Number,				
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exer-	ysfcian; To the best of my knowniner; On the basis of examinetiend menner steted.	vledge, deeth occurred et the ion end/or investigetion, in my	time, dete end pleca opinion, deeth occu	, end due to the ceu rred at the time, dat	use(s) and me te end place, e	nner es steted. and due to the cause(s)				
To the To the comp	29b. Signeture and title of certifier			193725		d. Date signed	(Month, Dey, Year)				
025-3	30. Name and address of person who of	completed cause of deeth (Item		River N							
State	31. Date filed (Month, Dey, Year) AUG 2 2	32. Registrarie Signet	ture A 1	ails		Jerich 1					
Registrar	HO0 2 2	cour proper	to the	cers							



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Robert /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) 4c. County of Deat Examiner Unsversi 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 12M 20F 240-14-9074 Usual Residence of Decedent Director 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 2120. 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 2 No Specify: Baltimore, Maryland 21215-0020 Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) HOME IMPROVEDENLE Z other 1 17. Father's Neme First, Middle, Lest) If Itam 27 is marked or Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Neme/Relationship (Type, Print) Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State
4 Denation 5 Other (Specify) 6 Department of Important: If IBN 23- Signature of Faderal Service Lio KATO. MO/0 4600 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical **Examiner** Be Completed by Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 Yes 2€No 1 ☐ Yes 2 No 25. Was casa referred to medical examiner? 26. Piece of Death (Check only one) Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Metural 2 Accident 5 Pending after deeth. 1 Yes 2 No investigetion the 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated. edical 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) BALL, monge 1059 eribe uni 1. Dete filed (Month, Dey, Year) 32. Registrer's Signeture Registrar AUG 22



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MENDED ITEM 4	‡18	PER FH G786 8/22/00 AH	State of Marylan		partment of F ertificate of			giene Reg. No.	10 26464
Physic /Medi		1. Decedent's Name (First, Middle, Las	3-ALLOW				2. Dete of Des Month AUGUS	Day	Year 4: 28 Pm
Examin Funeral Director		210-07-3743	Hospital a	est birthd	ey) If Under 1 Year Months Days	4b. City, Town, or Lo Randa LL S If Under 24 Hrs. Hours Min.		Bal	of Death L'more County 9. Birthplace (Stele or Foreign MD.
br F	9	Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town o	Location				10d. Inside City Limita
with the Maryland a or 28a-f show	to	MD N/A	В	ALTIM	ORE				XYas 2□No
or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
th wit	a a	4005 EMMART AVENU	E		212	15		U.S	.A.
5-0020 72 hours after death	by Funeral	11. Meritei Stetus 1X Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2. No If Yes, Give A. Year or Dates:	,S. 1	3. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bieck	- American Indian, t, White, etc.
T 6 1 4	Completed	15. Decedent's Edi (Specity only highest grad Elementery/Secondary (0-12)		(G lif	ecedent's Uauel Occupive kind of work done e. DO NOT use retire	pation during most of workind)	ing	16b. Kind of Bus	siness/Industry
	o Be Co	17. Father's Name (First, Middle, Last) ABRAHAM	GALLOW	500.		18. Mother's Neme		Maiden Sumame	MOLLIE POZEFSKY
and and	T	19e. Informent's Neme/Reletionship (T MRS.DELORES SCHERR	ype, Print)		eiling Address (Street BROOKMILI	t and Number or Rura	al Route Numbe	r, City or Town, S	State, Zip Code)
ges 1 and to of Heal		20e. Method of Disposition 1 XBuriai 2 ☐ Cremetion 3 ☐ I	20b. F	emetery.	sposition (Neme of cremetory or other ple		Date		City or Town, Stete
Baltimore, permit. Pages 1 at Department of Hear Important: If Item 2 my Injury or other after.		4 Donetion 5 Other (Specify, 21. Signature of Funeral Service Party	B'N			ess of Fecility SOL	LEVINSO	ON & BRO	S. INC.
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/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	a Multiple Due to (c	Or es a con	nan Systa	m faile	ve		
8760, sate be assouted bysician and the bunal-transit	al Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse, (Disease or injury	b. Castrol Due to co c. Anticoa	nte or es a con	sequenca of):	hemorrh	ige		
OX 6	an/Medical	thet initialed events resulting in deeth) Last	d. Pulmon		sequence of): Embc	plism			
death death ed for	sicie	Pert II. Other significant conditions co	ntributing to death but not res	ulting in th	e underlying cause gi	ven in Pert I.	23b. Did 1	obacco use con	tribute to the cause of death?
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Records, P The law requires that the has been signed b	Completed by Physician/M	chronic i	enal for	rele	ul		24e. Wes perfo	en autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Relationary Includes The law	Be Com	Chronic Ca 25. Wes case referred to medical	gnitive	dy	function	26. Plece of Deetl	1 D		1 Yes 2 No
Of Vita Physician: this certific ral director,	ToB	examiner?	Hospitel: 1 Inpatient 2	ER/Outpa	tient 3 DOA Ott	her:		dence 6 Othe	or (Specify)
Division of Vital Records, for Attending Physician: The law requires that releath. Director: After this certificate has been signed in by the funeral director, page 2 should be		27. Menner of Death 1 Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Tim Inju	e of 28c. Inju			now injury occurre	
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Div To the Hospital or within 24 hours afte To the Funerel Div completely filled in	edicai	29a. Certifier 1 Certifying Phy cone) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examine and menner steted.	wiedge, de tion end/o	eeth occurred et the ti r investigetion, In my o	ime, date and plece, opinion, deeth occurr	end due to the ed at the time,	cause(s) and mer date end pleca, a	nner es atated. nd due to the cause(s)
To the To the comple	Σ	29b. Signeture end title of certifier	112		29c. Licens	se number	2	29d. Date aigned	(Month, Dey, Year)
		Anjam	1017		D	76 66 3	5	Augus	t 19 2000
100-4		30. Neme end address of person who c	ompleted cause of deeth (Item	23a) (Ty	pe, Print)	y let by			
Sta	ate	31. Dete tiled (Month, Day, Year)	32. Registrar's Signe	ture	4 /	,			
Regist		AUG 2 2 2	2000 Dener	-21	D Apa	ris			

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death A Month HORNLETN **Physician** 0 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Sykesville Copper Carroll If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 122-09-3713 18 M 2 F 78 Yrs. **Director** Sep 15, 1921 New York Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Baltimore Lutherville Directo or 28a-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be 26 Atherton Road 21093 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1≧ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 8 Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. ğ 3⊠ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry T.A. James Food Elementery/Secondary (0-12) College (1-4or 5+) Sales Rep. 4 Products 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Edward Hornlein Esther (Unknown) and & 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hornlein -Son of of Health of It have 27 is 800 Macbean Lane, Cortland , New York 13045 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1₺ Burial 2 Cremation 3 Removal trom State Aug 23 2000 Dulaney Valley Memorial Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Parkville, Approximate 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca ot) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca ot): Box 68760. The law requires that the death certificate be Dua to (or as a consequanca ot) P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by page 2 should be 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Was en eutopsy 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Wes case reterred to medical 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Naturat 5 Pending Injury after death. 1 Yes 2 No 2 Accident invastigation 6 Could not be determined 3 ☐ Suicida 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tectory, offica building, etc. (Specify) 4 Homicide To the Funeral Completely filled To the Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner es stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DS2740 2 mestine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wright, Copper Ridge, 710 Obrecht Road, Sykesuille MD 21784

State Registrar

DHMH 16 Rev 6/95 APA A A 5664

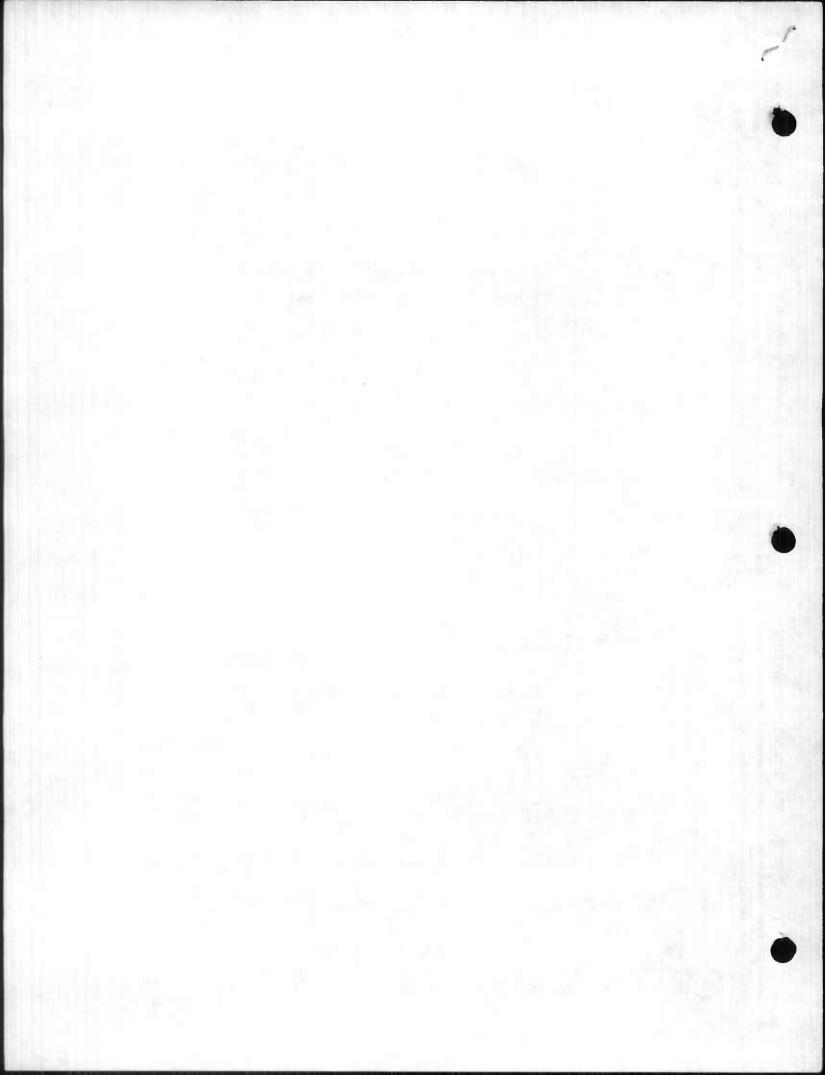
Ernestine 31. Date filed (Month, Day, Year)

AUG 22

2000

ORIGINAL

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey August 16, 2000 **Physician** Genevieve L. Holden 8:30 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore Manor Care-Ruxton Towson If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 1□M 2☑F 212-42-2401 81 Yrs. Director Jan 1, 1919 Marvland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Baltimore Parkville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2621 A. Proctor Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify þ 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen V. Constance John A. Farmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2621 A. Proctor Lane, Parkville, MD 21234 Ronald Holden 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Aug 19 2000 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery Rosedale, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Pa Parkville, Part1⁵ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of). Physician/Medical Examiner urinary reten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): autonomic neuro Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Medical Certification: To Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturai 5 Pending investigation NA 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

Examiner The law requires that the death certificate be executed Box 68760, the USB BB P.O. of Vital Records, page 2 should be Hospital or Attending Physician: After this Division f Director: Aff within 24 hours a To the Funeral C

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Saltimore, Maryland 21215-0020

filed within

Pages 1 and 2 should be nent of Health and Mental

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Department of Health important: If Nem 27

6 Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture end title of cartifier

29a, Certifier

MD

29c. License number

29d. Date signed (Month, Day, Year) 8 17.00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Iod 31. Date filed (Month, Day, Year) AUG 22

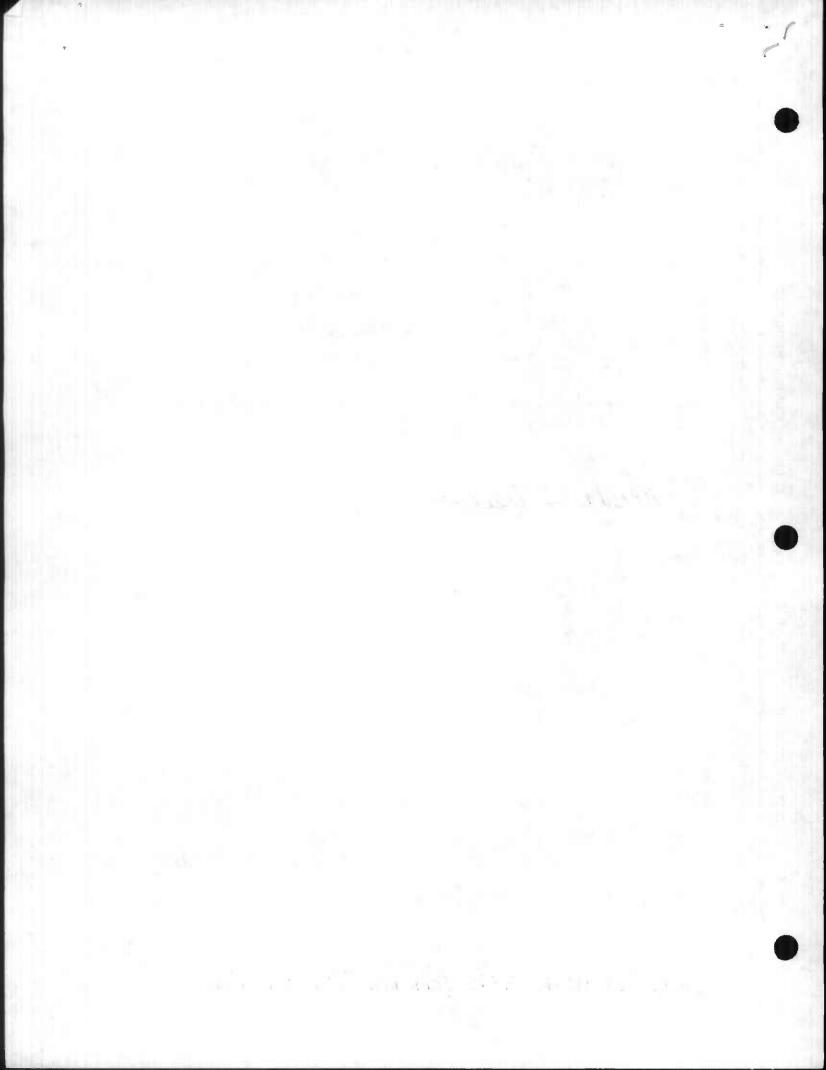
7825 VORK 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

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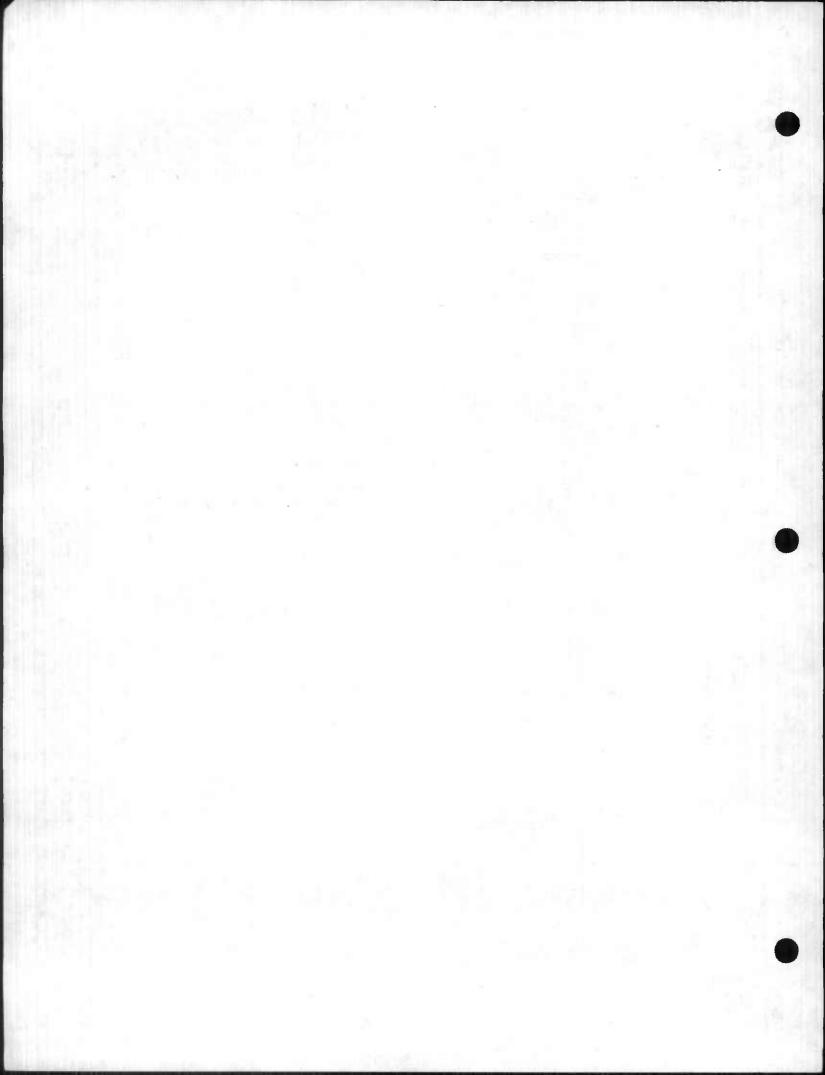
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State of Maryland / Department of Health and Mental Hygiene 00 26467

			Certificate of Death Reg. No.										
Physician,	Decedent's Name (First, Middle, L.	ast) Billie	D. Howell, Sr.			2. Dete of Month	Deeth Dey	Yeer	3. Time of Death 3 - 55 P				
/Medical Examiner	4a Facility Name (If not Institution, g Union Memorial	eath 4c. Count	y of Death	0.237									
funeral firector	5. Sociel Security Number 217-38-2979 Usual Residence of Decedent	Sex 7. Age (in yr. 15€M 2□ F 59	s. last birthday) Yrs.	If Under 1 Ye Months Dey		Min. (Month,	8. Date of Birth (Month, Dey, Year) March 24,1941 8. Birthplace (State or I Country) N. Caroli						
da or 28a-1 show it be notified at il Director	10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City I Maryland Baltimore Dundalk 1 Yes 2												
	10e. Streef and Number 8204 Peach Orch	ard Road		10f. Zip Code	212:	22	10g. Citizen of What Country? United States						
er, or itserie 23s Examiner must by Funeral	11. Maritel Stetus 1 Never Married 2 Nemied 3 Nidowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 「⊋Yes 2□ No ff Yes, Give Year or Dates: 196!	1	Vas Decedent of Yes, specify C		in? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra Ble Speci	ack, White,	e - Americen Indian, k, White, etc. :: White				
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went, the	17. Father's Name (First, Middle, Last	2 Years	Ro	Roofer 18. Mother's Nemo			Rod Idle, Maiden Sume						
To B	John Virgil Ho	well				a Lee Wil							
er traum	19a. Informant's Name/Reletionship Mrs. Roberta Hov						al Route Number, City or Town, State, Zip Code) Road Dundalk, MD 21222						
ary or oth	20a. Method of Disposition 1 ⊠ Buriel 2 ☐ Cremetion 3 4 ☐ Donation / 6 ☐ Other (Spec	□Removel from State	Plece of Dispos cemetery, crem ardens	etory or other p		Dete 8/23/2000	20c. Location Balti		wn, Stete Maryland				
any inju	21. Signifium of Fineral Service Licenses 22. Neme end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222												
sician	23a. Part1. Enter the disease, or co shock, or heert failure. List on	mplications that thused the de y one cause of each line.							Approximate Intervel Between Onset and Death				
edical iminer	Immediate Cause (Finel disease or condition resulting in death)	. A CUTE			DIAL	INFA	RETIOI	V	2 HOURS				
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cardificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit. Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of): Due to (or es e consequence of): Due to (or es e consequence of):												
	Part If. Other algnificant conditions	contributing to death but not re	23b. C	23b. Did tobecco use contribute to the cause of death?									
	END STAGE	RENAL DISE	ASE, H	YPEX	TEN	10N 1	Yes 2 No	Yes 2 No 3 Probably 4 Unknown					
	HYPER LIPID	EMIA	MIA					av	era autopsy findings ailable prior to mpletion of cause death?				
							☐ Yes 2☐ No	1[Yes 20 No				
	25. Was cese referred to medicel axeminer?	Hospitel:	26. Place of Death (Check only one) Other: 1 Lapstient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
To the Funeral Director: After this completely filled in by the funeral d	27. Menner of Death 1 Naturel 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Dey Year)	-	28d. Describe how injury occurred									
	3 ☐ Sulcide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - At building, etc. (Spec	on (Street end Num Town, Stete)	Number or Rurel Route Number,									
To the comp	29b. Signature and title of certifier			ense number		29d. Dete signed (Month, Day, Year)							
11	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) TOSEPH PUTHUMANA, WION MEM-1805P., BALTIMORE, MD.												
15+1	JOSEPH PL	ITHUMANA	, un	ION M	E19-1305	P. BALT	TIMORE,	MD	वावार.				
State Registrar	31. Date filed (Month, Day, Year)	32. Registrer's Sig	nature /	Ann	K								

ORIGINAL

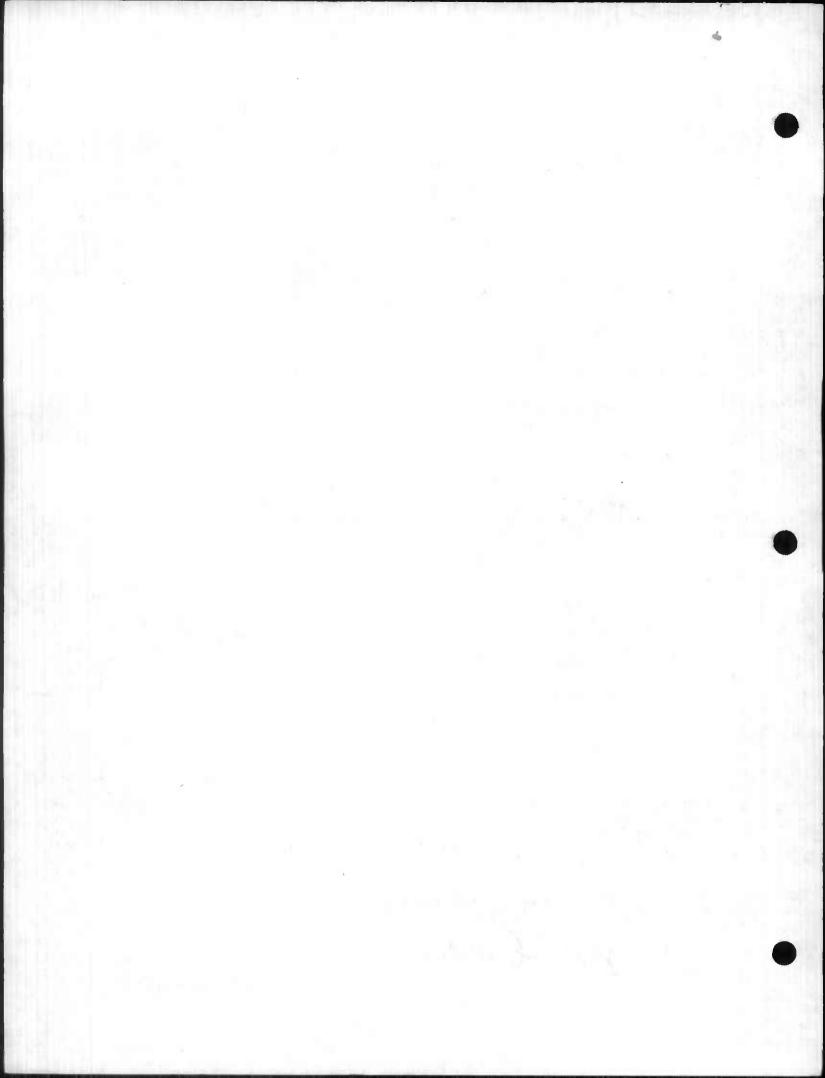
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

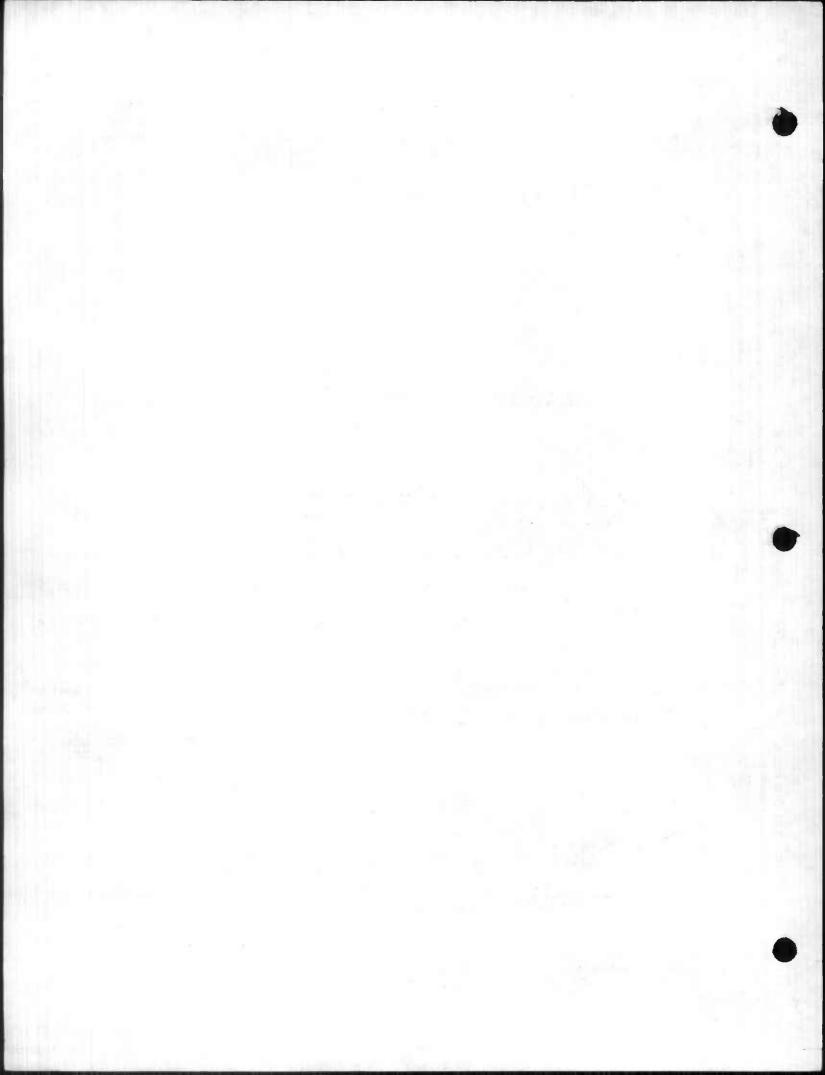
State of Maryland / Department of Health and Mental Hygiene 00 26468

	Centificate of Death Reg. No.														
Physician /Medical	Michael Hendriv									2. Date of Death Month Dey Yaa August 13 200			3. Time of Death 03:20 A.M.		
Examiner	4a Facility Name (//		4b. C			wn, or Lo	ocation of Dea	ath 4c. County of Death							
	Ro	oute 68	W/B east	of '	Vocke Ro	ad		L	aval	ale Allegany					
Funeral	5. Sociel Security N	umber 6.	S. Sex 7. Age (In yrs. I		yrs. lest birthday	Months	r 1 Year Deys		24 Hrs. Min.	8. Dete of B	irth Pay, Year) 9 1976	9. Birth	Birthplace (State or Foreign Country)		
Director	341-66-0784		1 M 2 F 24		Yrs.		50,0			02 29	9 1976		IL		
show dat	Usual Residence of														
	10a. Stete	10b. County	c. City, Town or L	ocation							10d. Inside City Limits				
notified notified rector	IL	didlothi.	lothian					1 2 Yes 2							
tor 28e-1 s be notified Director	10e. Street and Nun	10f. Zip Code						10g. Citizen	of What Cou	ntry?					
	3642 West 147th Place 60445											USA			
iner must Funeral	11. Marital Status	in U,S. 13.	J.S. 13. Wes Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F					o- 14. F		ace - American Indian,					
E 5	1 Never Merri	ed 2 Merried	Armed Forces? 1 Yes 2 No						n, Puerto	Hican, etc.)	Black, White, etc.		etc.		
by			If Yes, Giv	If Yes, Give Yeer or Detes:			1 ☐ Yes 2 ☑ No Specify:				Spe	Specify: Black			
		15. Decedent'e 8	Education		16e, Dece	dent's Usu	el Occup	ation			16b. Kind of Business/Industry				
Completed		ify only highest g	grade completed)		(Give	16e. Decedent's Usuel Occupation (Give kind of work done during most of willife. DO NOT use retired)			t of work	ing					
E	Elementery/Second	ndary (0-12)	College (1	1-4or 5+)		Yard Conductor				Railro		nd			
	17. Fether's Neme /	First Middle Las			Tard Coll			18. Mother's Neme (First, M.					au		
Be															
10	Cleotha							-	rlena Mays						
	19e. Informent's Ne									r Rural Route Number, City or Town, Stete, Zip Code)					
	Verlena l	dendrix/	Mother			2025 South Harvard,									
	20a. Method of Disp		CDamarial from State		Ob. Plece of Disp cemetery, cre	osition (Ne metory or (n (Neme of ry or other place)			Dete	20c. Location - City		or Town, Steta		
		5 Other (Spec	3 ☐Removel from State ecify)		Mount Hope Ceme					08 19	Chicago, I		L		
	21. Signature of Fu	neral Service Lice	ensee		1 2	2 Name e	nd Addre	ss of Fecili	ty						
Depa Maria Ma Maria Ma Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Ma Ma Maria Ma Maria Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma	Sterling-Ashton-Schwab Funeral Home 736 Edmondson Avenue, Balto, Md. 21														
	23a. Part1. Enter the shook, or hear	The free way	molications that o	aused the								. 212.	Approximate		
se as the burial-transit	Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of):														
Physician										1		1			
ys	Pert II. Other signific	Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.								23b. Did tobacco use contribute to the cause of					
d by Physician										1 Yas 2 No 3 Probably 4					
Completed by									24a. Wes an autopsy 24b			ere autopsy findings			
ete									per	formed?	e	veileble prior to empletion of cause			
du											O	f death?			
00										10	MYes 2 No	1	ØYes 2□ No		
To Be Com	25. Was case refer	25. Was case referred to medical 26. Place of Deeth (Check only										y one)			
To	examiner?	No	Hospitel:	Inpatient	2 ER/Outpetie	nt 3 D	OA Oth	ner: 4 🗆 Ni	ursina Ha	me 5 Res	sidenca 6 X	Other (Spec	ib) Scene		
	27. Menner of Death		28a. Dete	of Injury	28b. Time		_				how injury oc	curred DA	CIVER OF		
100	1 Netural	5 Pending investigetion	on QIII	Dete of Injury (Month, Dey Yang) 128b. Time of UND Injury Work? 1 Yes 2 No					No	AUTO THAT STRUCK A FIXED					
158	3 Suicide 6 Could not be 28e Place of Injury - At home form street fectory office									281. Location (Street and Number or Rural Route Number.					
Certification:	4 Homicide	determine	building, etc. (Specify)									LAVACE MA			
2	On Cartina	4 T A . # 1	A	1	HIGHWI										
Ica	29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and mannar as stated. Check only one														
completely filled in by the fu Medical Certification	or in the state of									ned /Month	(Month Day Veer)				
3	250. Signeture and	0	29c. License number O.C.M.E.				29d. Date signed (A			onui, Day, Year)					
17		13,					August 14, 2000								
10	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)														
U	MAR	4 G.R	IPPLE,	m.D.	111	Penn	Stre	et, E	Balti	more,	Marylar	nd 212	01		
State	31. Date filed (Mont	h, Dey, Year)		legistrer's	Signeture	di .	1								
Registrar	1	MG 2 2	2000	23,000	sport of	1 1	11/2	and the same							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Neme (First, Middle, L.)	act)		Certifica	te of Dea	ath	2. Date of De	Reg. No.	3. Tima of Death	
Phys	sician	WALTER		=ex1=	ナフ			Month	Day	Year	
100	edical	4e Facility Name (If not institution, gi			11 6-	4b Ci	ty, Town, or Lo	AU6US			
Exa	miner	NORTHWEST		1500	-0	-	INDAL		,	TIMORE	
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Funer Direct			1 X OXM 2□ F		Yrs. Months		ours Min.	8. Dete of Bird (Month, Da Aug 11	y. Year) 1919	9. Birthplace (State or Foreign Country) Maryland	
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the Me	cto	Maryland Baltimo	re	Woodlas	vn					1 ☐ Yes 文□ No	
th with the M 23a or 28a-f	Director	10e. Street and Number				ip Code			10g. Citizen of W	hat Country?	
ath w		2166 Lorraine Ave				1207			USA		
-0020 Phours after de stural', or Nema	by Funeral	11. Meritet Stetus 1. Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 X 1 Yes, Give Yeer or Detes:		13. Was Dec	edenf of Hispan ecify Cuban, Me 2000 Sp		cify Yes or No Rican, etc.)		- American Indien, k, White, etc. White	
72 hours	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Us	uel Occupation ork done during	most of worki	na	16b. Kind of Bus	siness/Industry	
121 ighin	hple	Elementery/Secondery (0-12)	College (1-4or 5	+)	life. DO NOT	use retired)	,				
other ti	S	U	0		N/A	140.6	M-M - 4- M	dFire Adiable	N/A	-1	
id be filed ental Hygical distribution	Be	17. Father's Neme (First, Middle, Las				18.1	MOINETS NEME	(First, Middle,	Maiden Surname	9)	
Maryland d 2 should be file th and Mental Hy 7 is marked oth	2	Walter H. Herbl 19a. Informent's Neme/Reletionship		106	Maiting Address	e (Ctmat and A	Lillia	in Crut	chley er, City or Town, S	State Zio Code)	
Ma d 2 s th an		Richard W. Herkl									
Te, Hear tem tem		20a. Method of Disposition	orz brown	20b. Plece of	Disposition (Na	ame of	e Ave.	Date	un, Md	ZIZU/ City or Town, State	
Baltimore mit. Pages 1: mentinent of He		XXBuriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci			y, cremetory or on Park	other piece)	8-	12-00	Baltimo.	ro Md	
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m and	900	herry loh	1	2-10-1	61:4	l . T	0 11	12			
-		23a. Part Enter the disease, or con shock, or heart failure. List only	polication that caused	the death. Do r	of enter the mo	Edmond	ch as cardiac of	Cato	tonsville, Md. 21228 tory errest. Approximete		
Physicia	20	shelck, or heart failure. List only	one gause on each lin	10.						Intervel Between Onset and Deeth	
/Medic		tmmediete Cause (Finet	VIENT	PICULA	R	FIR	OILLA	TION		40 MINUTE	
Examin	er	disease or condition resulting in deeth)								1 / C FINOUIC	
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So, se se se sian sian s		Sequentielly tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Hupa	SITEL	SIVE	CARO	10 Un:	SWLAR	. DISEAS	E YEARS	
68760 ificate be a g physician as the buria	edicai	thet initieted events resulting in deeth) Lasf		Due to (or es e c							
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. Box death cert e attendin of for use	ian										
	by Physician/M	Pert II. Other aignificant conditions	contributing to death bu	ut not resulting in	the underlying	cause given in	Part f.	23b. Did		tribute to the cause of death	
P.O. that the ed by the detache	栕	CONGESTIVE	MEAN	F	SILUR	E		10	Yas 2 No	3 Probably 4 Unknow	
Records, P.O he law requires that the has been signed by th age 2 should be detach	d b							24a. Wes	an autopsy	24b. Wera autopsy findings	
cord v require been si	Completed							perfo	rmed?	evailable prior to completion of cause of death?	
m = = %	dmo								1		
0	S	25. Was case referred to medicat				20	Disease Death	10		1 Yes 2 No	
C # 5	AP	axaminer?	Hospitet: 1 Dipostio	nt 2 TER/Ou	tnotiont Tr	Other	Place of Deeth			or (Specify)	
Vital I	uner this certification uneral director on: To Be	1 Yes 2 No		28e. Dete of trijury (Month, Dey Year) 28b. Time of Injury M 28c. finjury at Work? M 1 Yes 2 No					g Home 5 ☐ Residence 8 ☐ Othar (Specify) 28d. Describe how injury occurred		
Phys ral di	ition: To E	27. Menner of Death Death Death Secure 5 Pending	28e. Dete of trijui (Month, De)	Year) 28b. T			2 No				
Phys ral di	ertification: To E	27. Menner of Death	28e. Dete of trijur (Month, De)	ary - At home, fe	М	1 Yes		28f. Location (. City or To	Street end Numbe vn, State)	er or Rural Route Number,	
Phys ral di	edicai Certification: To E	27. Menner of Death 15 Returel 2 Accident 3 Suicide 4 Homicide 29a. Cartifier 27. Menner of Death 5 Pending Investigetic 6 Could not to determined	28e. Dete of trijur (Month, De) 28e. Plece of triju building, etc	ury - At home, fe :. (Specify) of my knowledge examination and	m, street, fecto	1 ☐ Yes ry, office d et the time, da	ate and place,	City or To	vn, State) cause(s) and mer	er or Rural Route Number,	
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Division of Vita To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification: To E	27. Menner of Death 1 Sleturel 2 Accident 3 Suicide 4 Homicide 29a. Cartifier (Check only one) 27. Menner of Death 5 Pending investigetic 6 Could not to determined	28e. Dete of tnjur (Month, De) 28e. Plece of tnjur building, etc nystcian: To the best of miner: On the basis of and menner ste	ury - At home, fe c. (Specify) of my knowledge examination end	m, street, fector death occurred for investigation	1 ☐ Yes ry, office d et the time, de n, in my opinior c. License num	ate and place, on, death occurrent	City or Ton	cause(s) and mer date end plece, a 29d. Dete signed	er or Rural Route Number, nner es stated. Ind due to the cause(s) I (Month, Day, Year)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. ADH State of Maryland / Department of Health and Mental Hygiene ADOLPHUS HARDING Certificate of Death 00-4619-005 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death JOHN HARDING **Physician** AUGUST 16, 2000 1328 PM /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not Institution, give street and number Examiner 2700 ROLLING ROAD WOODLAWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Sex 1₽M 2□F Hours Yrs. Director 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits BALLIMORE 1 □ Was 2 □ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 238 MRWICK Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Ricen, atc.) 1 res 2 No If Yes, Give Year or Detes: 21215-0020 1 Yes 2 No Specify: Aq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Maryland 17. Fether's Name (First, Middle, Last) 1 and 2 should be 11 leasth and Mental H im 27 is marked off ENORA (UNKNOWN 19e. informent's Neme/Reletionship (Type, Print) of Health a vit. If Item 27 is Baltimore. 20e. Method of Disposition Pages 1 Buriel 2 Crametion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Approxynate interval Betw 23a. Pert1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disease or condition resulting in deeth) MULTIPLE FNJURIES /Medical **Examiner** Due to (or as e consequence of) Examine Sequentielly list conditions, if eny, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consaquance of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? P.O. 1 Yes 2000 3 Probably 4 Unknown CARDIONASCULAR ATHEROSCLEROTIC ρ Records. 24b. Were sutopsy findings svailable prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed Oyas 2 No 1 es 2□ No of Vital 25. Wes cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Mother (Specify) AT SCENE Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 1X Yes 2 No Medical Certification: To 28d. Describe how injury occurred CINDER BLOCK 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Hospital or Attending Pl 124 hours after death.
 Funeral Director: After the Division 1317 PM 5 Pending investigation 1 Neturel 8/16/00 Yes 2 No 2 Accident
3 Suicide WALL FELL ON SUBJECT 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 2700 Locumber RO 28e. Ptece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 — Certifying Physician: To the best of axmination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 — Medical Examiner: On the basis of axmination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a Certifier To the To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

AUG 2 2 2000

31. Data filed (Month, Day, Year)

MARY G. RIPPLE, M.D.

30. Name end eddress and irson who completed cause of death (item 23e) (Type, Print)



111 Penn Street, Baltimore, Maryland 21201

OCME

AUGUST 17, 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 2 6 1 7 1

					,	Certifica	ate of	Death		Reg. No.	0 2041	
			Decedent's Neme (First, Middle, La						2. Dete of 0 Month	Peeth	3. Time of De	eath
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<i>)</i>	Examiner	40	Facility Name (If not institution, give			, , /	1	4b. City, Town, or			of Death	
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,	Funeral Director	21		M 2₽+	In yrs. last	Yrs. Monti				Y-28	9. Birthplace (Stele or F Country)	oreign
200	ahow adm	-	. State 10b. County	1	Oc. City, T	own or Location					10d. Inside City I	Limits
Mon		1	ND		136	1/2/1	mo	&E			1 € Yes 2	□ No
And the state of t	or 28a-1 a	10e	. Street and Number	,			Zip Code		Harry.	10g. Citizen of V	/het Country?	
4	23.		1306 KOD		14	14	21	206		U.	5.14	
5-0020	at, or its		Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	er in U,S.	If Yes, s	cedent of specify Cul	Hispanic Origin? (Spen, Mexican, Puer Specify:	Specify Yes or fi to Rican, etc.)		e - American Indian, k, White, etc.	-
			15. Decedent's Ed (Specify only highest gra	ducation ade completed)	1	6a. Decedent's U	suel Occu	pation during most of wo	nking	16b. Kind of Bu	siness/Industry	
121		E	lementery/Secondary (0-12)	College (1-4or 5+)		life. DO NO	T use retire	od)		MHIA	TENIANI	15
9 2			Father's Name (First, Middle, Last,			057	041	18. Mother's Ne	me (First, Midd	le, Maiden Surnam	TENUNI	22
ylan	2 T T T		Austin ,	IACKSO!	11			MHD	44		NON	
6 0	PEE	196	o. Informant's Neme/Reletionship (19b. Meiling Addr	ess (Stree	at end Number or R	urel Route Num			
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more	200	200	. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐	Removei from State	20b. Piece ceme	e of Disposition (/ etery, cremetory of	Neme of or other pla	ace)	Dete	20c. Location -	City or Town, State	
	P 40 23		4 Donetion 5 Other (Specif	y)	KING	MENO	RILA	PARK	8-21-00	EMOORE	15 toww, 1	10
Balti	Department Important: hand lajury o	21.	Signature of Funeral Service Licer	Hair	a	22. Name	and Addr	65 of Facility	HOYS	FUNZ	FULL BON	ule
		230	Part Enter the disease, or com shock, or heart feilure. List only	plications that caused the	e death. I	Do not enter the n	node of dy	ing, such as cardle	o or respiratory	arrest,	Approximete Intervai Between	en
	hysician										Onset and Dec	
	/Medical xaminer	dis	nediete Cause (Final ease or condition ulting in death)	a	SE	PSIS					5 day	45
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Ta da	sician and burial-transit			b		a consequence	1	ADIAL	INFAR	LILON	7 009	3
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P.O. Box	the the	Part	II. Other significant conditions of	ontributing to death but	not resultin	ng in the underlyin	g ceuse g	iven in Pert I.			tributa to the cause of	
م ع	igned by be detac by Ph							7 KE 13	11	Yas 20190	3 Probably 4 Un	iknown
Division of Vital Records, P	tate has been signed in page 2 should be det	_								es en eutopsy formed?	24b. Were autopsy find evailable prior to completion of cau of death?	
Re de	age 2								10	Yes 2 No	1 ☐ Yes 2NNo	0
ita		25.	Was case referred to medical					26. Plece of De	eth (Check only			
of Vita	5 P		examiner? 1 Yes 2 No	Hospitel: 1 Denpatient	2□ER	/Outpatient 3□	DOA O	ther: 4 Nursing	Home 5□Re	sidence 6 Oth	er (Specify)	
0 0	ther the		Menner of Death 1 DNetural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Y	'ear) 28	b. Time of Injury	28c. Inju		28d. Describ	e how injury occurr	ed	
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	1/2	30.	Neme and address of person who	completed cause of dea				0		AUGUST		
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and the second of the second 234 In 35 365 Phillip Town 18 1 2 CHELLINE TO SEE STORT OF THE REPORT OF THE STORY

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HUNTER ROBINA Augusti. 2000 17=20 /Medical 4a Facility Name (ff not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARPORD FALLSTON HOSPITAL ER FALLSTON GENERAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2 F Director 175-24-1591 89 Aug 29, 1910 | Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Director r than "natural", or items 23a or 28a-f the Medical Examinar must be notified Monkton 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2904 Houcks Mill Road 21111 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 14. Raca - Amarican Indian Black, White, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White ð 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Front Clerk Hotel Accomodations 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of To Laverick Robert Judith Anna Edgar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Karen A. Myers (Daughter) 2904 Houcks Mill Road, Monkton, Maryland 21111 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Separtment of Health reportant: If them 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ABurial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Special) Lloyd Cemetery 8/28/2000 Ebensburg, PA 21. Signatury of Furna Seur 22. Name and Address of Facility Lawson Mitchell-Wiedefeld Funeral Home, Inc. Martin D. one that ceused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, Mary Land 21212 august on each line. 23a. Part 1. Enter the disease, or complical shock, or heart failure. List only one Interval Between Onsat and Death Physician /Medical Immediate Cause (Final diseasa or condition resulting in death) ASCUD Examiner Due to (or as a consequence of): Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting In death) Last Due to (or as a consequence of): certificate be execu Physician/Medical Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by HYPERTENSION þ 9 24b. Ware autopsy findings Completed 24a. Was an autopsy performed? ATMAL FLUTTER peed available prior to complation of causa of death? certificata has MITRAL REGURGITATION 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 □ PVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Nes 2 No After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. Licanse number OCME 17 2 000 30, Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

State Registrar GPNAB HUMID

AUG 2 2 2000

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

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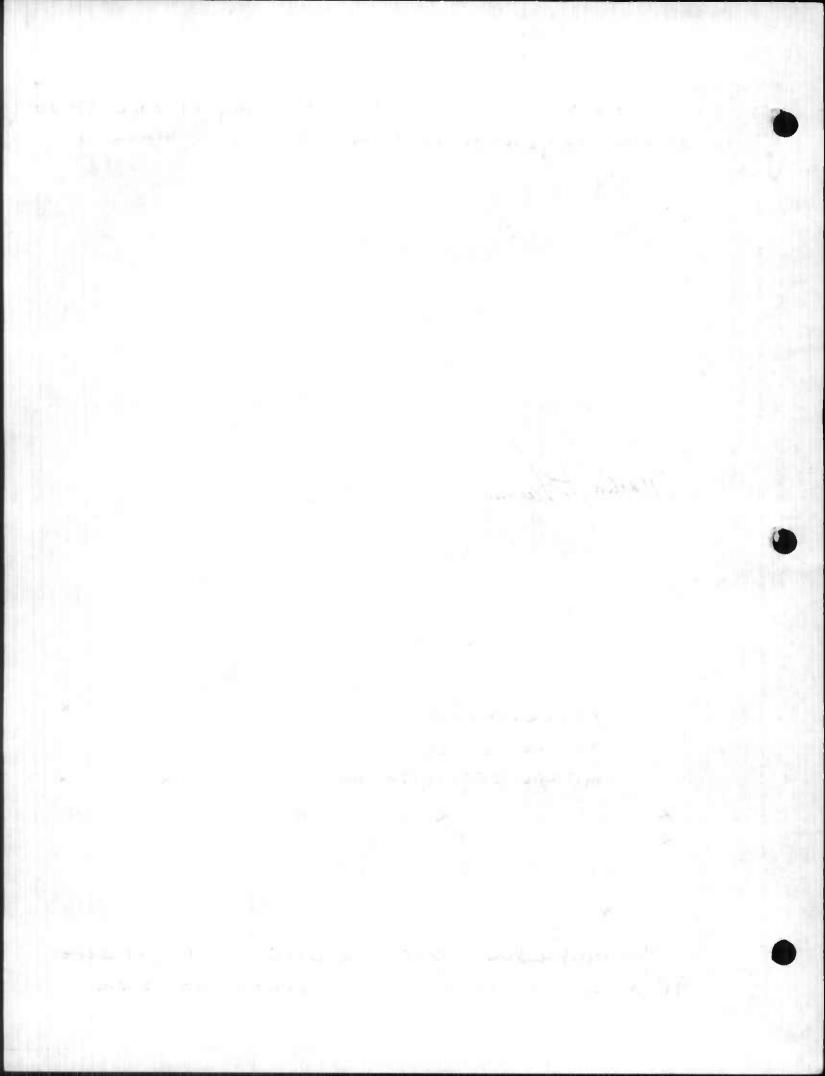
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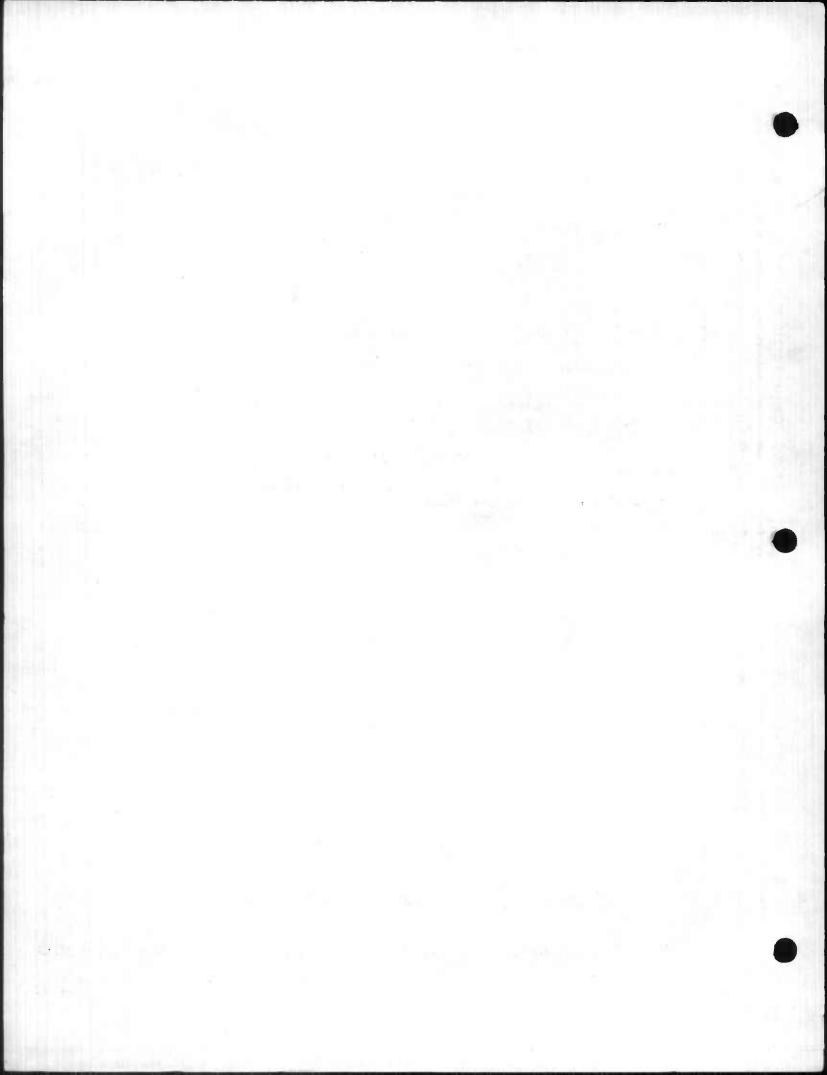
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director		5. Social Security 220-07-	5715	Sex 1□ M 20 F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Yaa Months Day		8. Data of Bir (Month, Da July	th Year) 1920	9. Birthi Cour Ma	place (Stata or Foreign ntry) ryland
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	N THE	5	MD	N/A		Bal	ltimor						13Q Yas 2□ No
		al Director	10e. Street and No.	_{imber} ndre Str	eet			10f. Zip Code 2123		100	U.S.A		ntry?
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26474 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Year **Physician** KATHARINE LAMNECK HIBBEN 17,2000 AUGUST /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death BROOKE GROVE KEHABILITATION AND WISING HOME SANDY SPRING MONTGONERY 8. Date of Birth (Month, Day, Year) Jan 3, 1912 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 578-62-8433 Birthplaca (State or Foreign Country) Yrs. OH Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgarery Sandy Spring Director 1 ☐ Yes PNO No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18100 Slade School Road 20860 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Yas 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: À Specify: White 3X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Hôme 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Arthur Phillip Lamneck Elsa Harriet Strong 2 19a. Informant's Name/Relationship (Typa, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Philip C. Meade, Jr. 4328 Montgomery Avenue, Bethesda Maryland 20814 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Union Cemetery August 21, 2000 PortWashington, CH 4 Donation 5 Other (Specify) ature of Funeral Sancial Licansee Victor P. Doda, Jr. 22. Nama and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA disease or condition resulting in death) Dua to (or as a consequence of): DUSPHAGIA Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Dua to (or as a consequenca of): STATUS POST CRANIOTOMY Due to (or as a consequence of): SUBDULAL HEMATOMA FALL FROM Part II. Other significant conditions contributing to death but riot rasulting in the underlying caus 23b. Did tobacco use contribute to the cause mp 1 Yes 2HNo 3 Probably 4 ☐ Unknown ALZHEIMER'S DISEASE 24s. Was an autopsy 24b. Were autopsy findings available prior to n of cause 13 1□Yes 22TNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 27. Manner of Deeth 28b. Time of PM 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending investigation 1 Netural FALL FROM CHAIR 1 Yes 2 No JUNE 30,2000 ~ 8:00M 2 Accidant 3 Suicide 6 ☐ Could not be 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) BLOOKE GROWN ASSISTED LIVING -28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) KNOUL FOAD SANDY SPEING, MALY LAND 4 Homicide

Box 68760. Pe O Records.

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena.
Important: If team 27 is marked other than "natural", or itama 23a or 28a-1 show any lijury or other traumatic avent, Iffe Medical Estaminar mail to nother traumatic avent, Iffe Medical Estaminar mail to nother traumatic avent, Iffe Medical Estaminar mail to a round and a property of the medical Estaminar mail to a round and a property of the medical Estaminar mail to a round and a round and a round and a round a round and a round and a round a r

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(Check only one)

Baltimore, Maryland 21215-0020

State Registrar

29b. Signatura and titla of certifiar ATTENDING 29c. License number

Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

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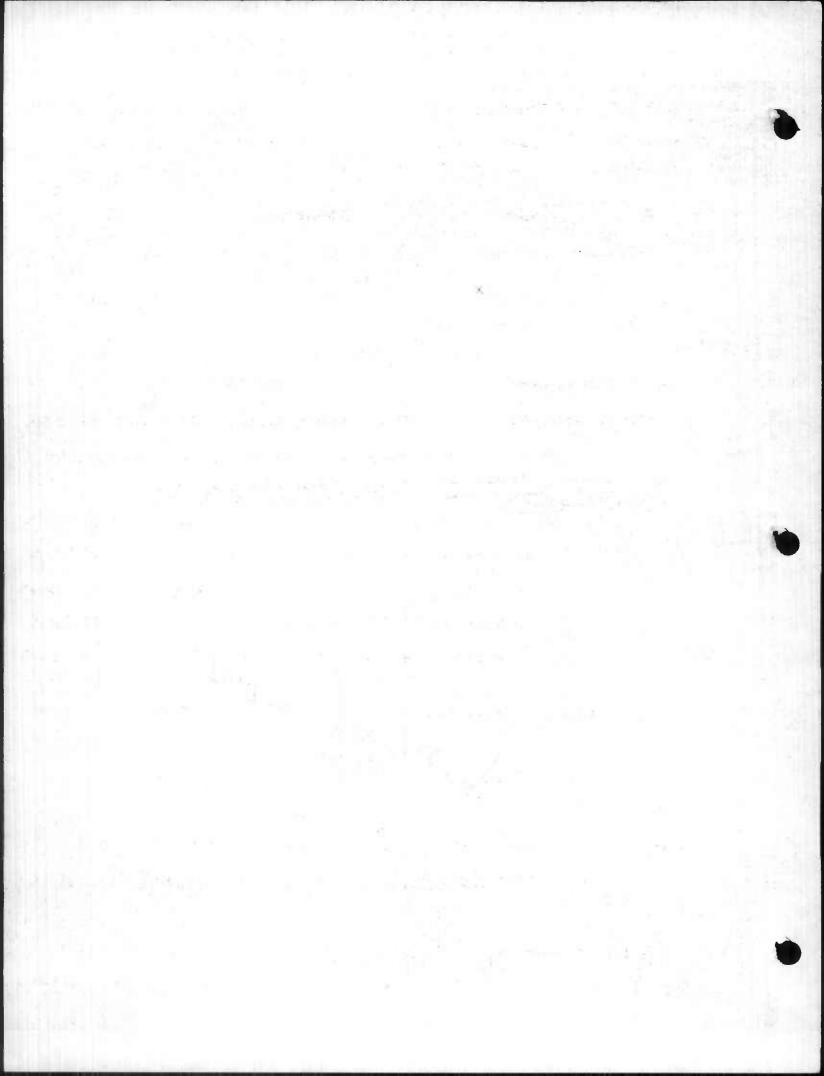
D42046

August 17, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

31. Date filed (Month, Day, Year) AUG 2 2 2000 32. Registrar's Signature



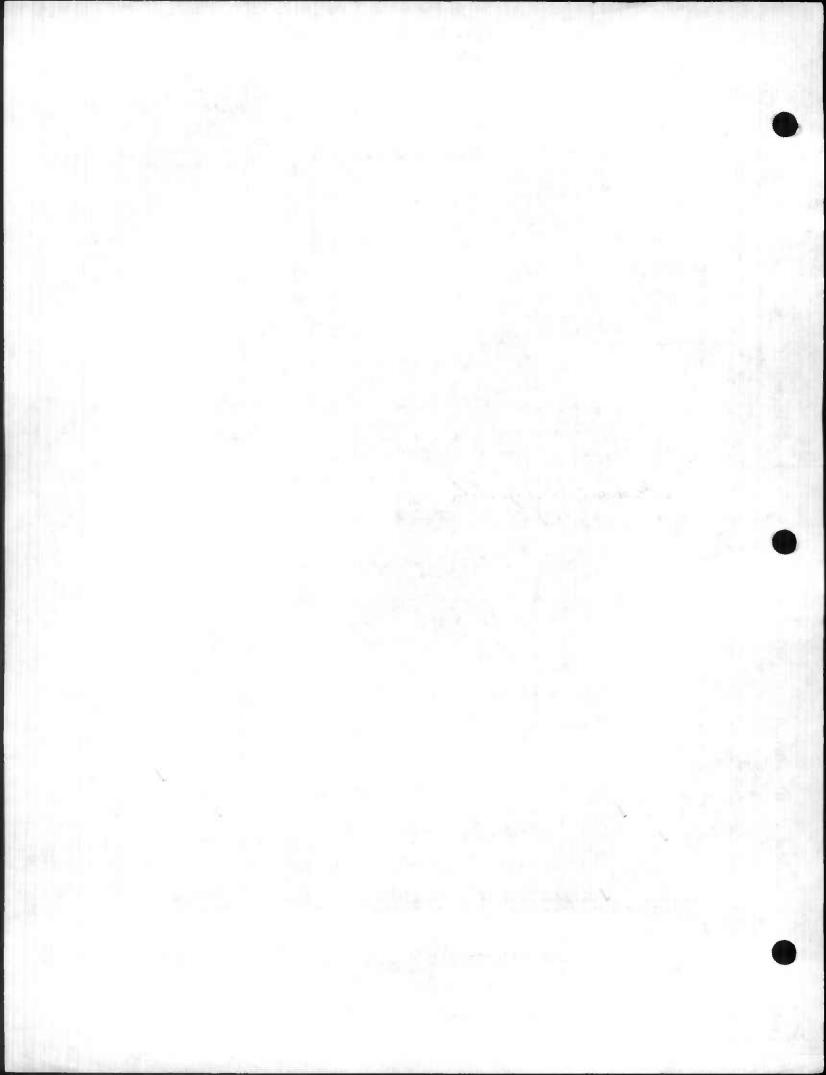
State of Maryland / Department of Health and Mental Hygiene

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James A. Quinlan, M.D. 7801 York Road Towson, MD 21204 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4		Hert (2 venta	MS	D1:	2990	7 - 1	August	19,	2000
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	6					Towson	n, MD 2	1204		
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Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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iysician Medical	1. Decedent's Nam ALEXANI	ne (First, Middle, La: DER	st)		IT	KIN				2. Data of Dea Month AUGUST	18y	2000	3. Time of Death 6:45AM
aminer	4a Facility Nama (If not institution, giv GHT PLUME	a street and nu	ımber)				4b. City, To		ocation of Death	4c. County HOWAF	of Death	
ral tor	5. Social Security N 220–35–98	361 2	ex M 2DF	7. Aga (In yrs. 59	last birthday) Yrs.	If Unde Months	or 1 Year Days		24 Hrs. Min.	8. Date of Birt	4 14941	9 Birtho ROS	ace (State or Foreig 51A
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	10a. State	10b. County			ty, Town or Lo	cation						1	0d. Inside City Limits Yas 2□ No
9	MD	HOWARD		COL	UMBIA								YAJYAS ZUNG
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Completed	Elementery/Second	cify only highest gra ondary (0-12)		(1 <u>55</u> qr 5+)	MECHA	NICA	use retin	pation during mos ed) IGINEE	R	ing .	ENGINEE	RING	
To Be C	17. Father's Name SAMUEL	(First, Middle, Last)	IT	KIN				SOPH	er's Name YE	e (First, Middle,	Meiden Sumar LOK	SHINA	
To	19e. Informant's N	ame/Relationship (Type, Print)							al Route Numbe			
	ANNA ITK	IN/WIFE			6267					COLUMBI	A, MD.	21044	
	20a. Method of Dis			20b. F	Place of Disponentery, cres	sition (Na	ame of	ace)	1	Dale	20c. Location	City or To	wn, State
5	Burlal 2 4 Donetion	☐ Cremation 3 ☐ 5 ☐ Other (Specify	IRemoval from y)	State	UMBIA				8,	/20/00	COLUMB	IA, M	D.
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any injury o	· Re	-	7		00	000 B	PTC	רבים כיתי					. 21208
bunal-transit cal Examiner	Immediata Cause disaase or condition resulting In death)	on	a	vetust Due to (c	or as a consec			nallCe	2117	ung (ance	~	8 months
Completed by Physician/Medical Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease of that initiated event	onditions, mmediate erlying r Injury	b	Due to (d	or as a consec	quence of):						
Medic	resulting in death)	s Last	d	Dua io (d	or as a conseq	uance of)):	2 38	¥				
sician	Part II. Other signi	ficant conditions o	ontributing to d	leath but not res	sulting in the u	nderlying	cause g	iven in Part	1.	23b. Did 1	tobacco usa po	ntributa to	the cause of death
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ToE	examiner?	No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 🗅	OA O	ther: 4 N	ursing Ho	ome 5 Resid	dence 6 Oti	ner (Specif	v)
cation: To Be (27. Manner of Dea 1 Matural 2 Accident		28a. Date (Mor	of Injury nth, Day Year)	28b. Tima o Injury		28c. Inj				how Injury occu		
ertifice	3 Suicide 4 Homicide	6 Could not be determined	28e. Place	e of injury - At hi ling, etc. (Specif	ome, farm, str	reet, facto	ory, office)		28f. Location (: City or Tox	Street and Num wn, State)	ber or Rura	I Route Number,
edical Certification:	29a. Certifier (Check only one)	1 Certifying Ph 2 Medicat Exam	niner: On the b	e best of my kno casis of examina nner steted.	owledge, deetl ation and/or in	h occurred vestigetio	d at the t	time, date ar opinion, dec	nd place, eth occur	and due to the red at the time,	ceuse(s) end m date and plece,	anner es s and due to	tated. o the cause(s)
Medical Cel	29b. Signature and	4 -1-4 4 -144				1.0	0	asa number			29d. Data signe	4 (34 - 4	B - 1/ - 1

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th State

Registrar

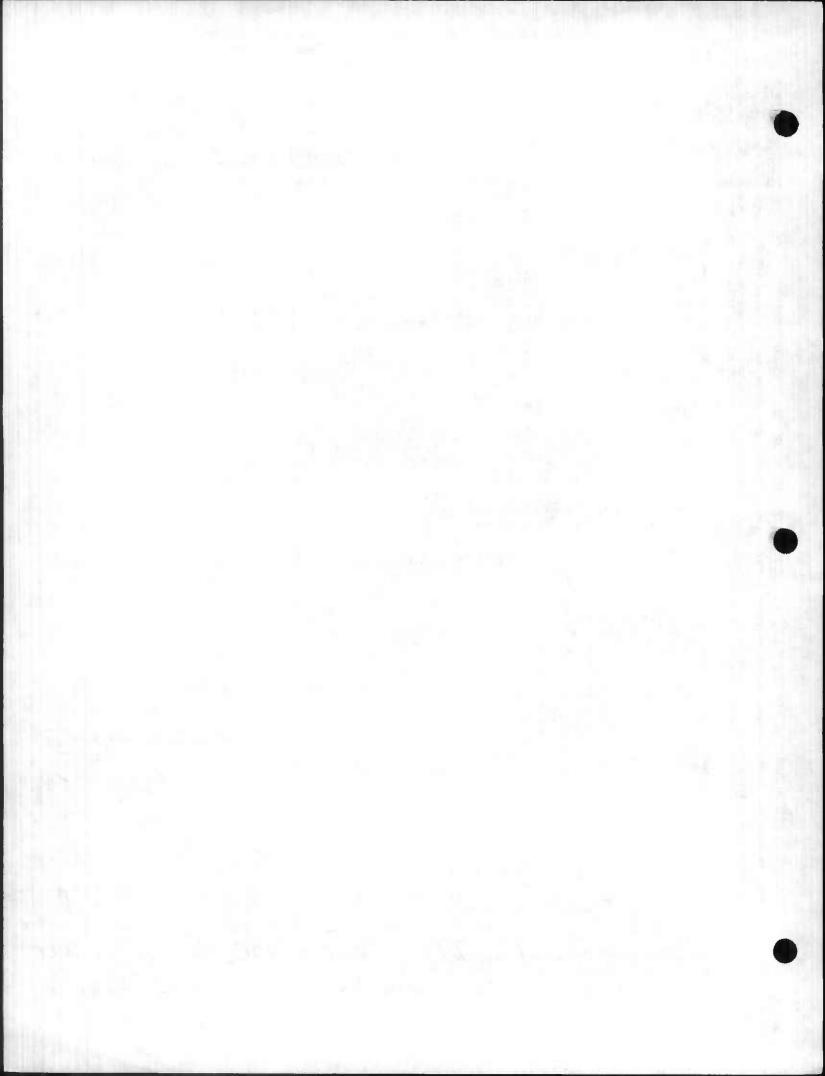
29d. Data signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

D Ja has Hopkins Hospital.

182. Registrar's Signature Ana Ka

Jute RBrahmer, MD
31. Date filed (Month, Day, Year)
AUG 2 2 2000



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month August 20, 2000 **Physician** Jong Sik Jun 6:30 PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 25, 1955

Birthplaca (Stete or 1)
Country Korea 5. Social Security Number If Under 1 Year 9. Birthplaca (Stete or Foreign 7. Age (In vrs. last birthday) **Funeral** 10 M 2□F Months Deys 220-51-7073 44 Yrs. Director Usuel Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Directo Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 mant be n 21035 900 Eastham Court #12 South Korea 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 8 Asian 1 ☐ Yes X No Specify: à 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Tailor Clothing permit. Pages 1 and 2 should be file. Department of Health and Montal Health and Mon 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Sun Gi Hong Song Gi Jun 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) In Hee Jun / Daughter #12 Crofton, MD 21035 900 Eastham Ct. 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial ※ Cremation 3 ☐ Removal from State Metro Crematory Aug. 22, 2000 Catonsville, MD 4 Donalion 5 Qther (Spesity) 21. Signature of Furieral Service Licanse 22. Name end Address of Fecility Kirkley-Ruddick Funeral Home P.A. 23e. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximately a such as cardiac or respiratory errest,

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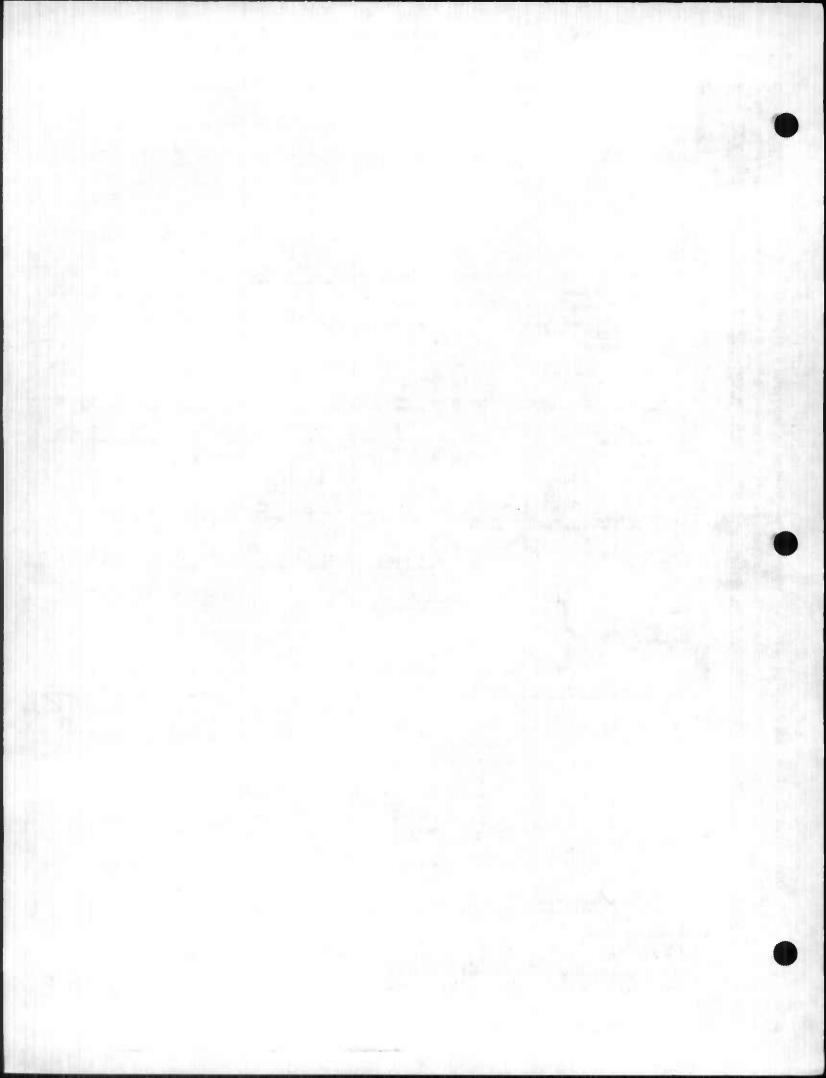
Approximately a such as cardiac or respiratory errest, Approximete Interval Between Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in deeth) Metastatic Malignancy of Unknown Origin /Medical Examiner Due to (or as a consequence of) Examine attending physician and for use as the bunal-trans Sequentially liat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequença of) 68760 Physician/Medical Due to (or es e consequença of) Box (signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of grath? 1 Yes 2 No 3 Probably 4 Unknown by of Vital Records. 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed has page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medicat exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA edical Certification: To this 27. Menuler of Death 1 Natural 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. tnjury et Work? 28d. Describe how injury occurred al or Attending P safter death.

I Director: After the in by the funers Division 5 Panding investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled in Two Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number ich III M.D. August 20, 2000 D41365 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 301 Hoxpital Drive, Glen Burnie, MD. George E. Wicks Tot 31. Dete tiled (Month, Day, Year) 32. Registrer's Signeture State AUG 2 2 2000 Registrar

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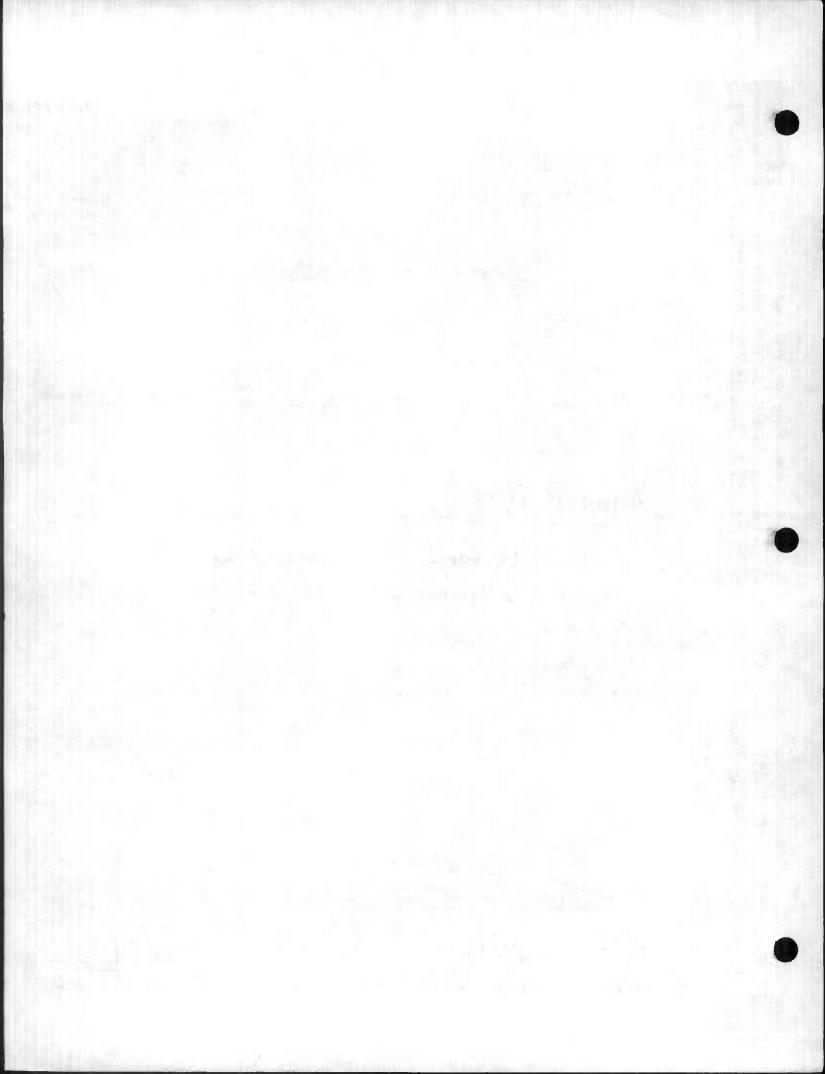
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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			Certificate	or Death	Re	g. No.	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Vinie L. Kn				2. Dete of Deeth Month August	Day Year 18,2000	3. Time of Deeth 9:55 PM
Examiner	4e Fecility Neme (If not institution, give street e 5106 Forge Road	and number)		4b. City, Town, or Perry		4c. County of Death Baltimo	
Funeral Director	5. Sociel Security Number 425-54-6551 Usuel Residence of Decedent	7. Age (In yrs. Is	Yrs. If Under 1 Y	-		9 Rint	nplace (Stete or Foreign untry) SSISSIPPI
or 25a-f show be notified at Director	10a. Stete 10b. County		Town or Location			MARCH 1	10d. Inside City Limits X₁X Yas 2 No
or 25e.f s be notified Director	10e. Street and Number		10f. Zip Co	de	10	0g. Citizen of Whet Co	untry?
23a cust by unit by un	5106 Forge Road			21128		USA	
020 urs after des af, or flems Examiner in by Furrer	1 Nevar Merried 2 Merried	is Decedent Ever in U.S ned Forces?] Yes 그런 No 'es, Give ar or Datas:	13. Was Deceden If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puen No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ama Black, White Specify: W	
and within 72 hours at yellow are than "central," or or than "central," or or than "central Exam Completed by I	15. Decedent'a Education (Specify only highest grade comp		16a. Decedent's Usual C (Give kind of work of life. DO NOT use r	one during most of wo	rking	16b. Kind of Business/	industry
	Unknown	llege (1-4or 5+)	Homema	aker	Timb Aliable A	Own Home	9
and dos mall	17. Father's Neme (First, Middle, Last) Sist	runk			ne <i>(First, Middle, N</i> known	neidett Sumetha)	
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Manda anda er tra	Thomas Raines	Son	5106 For	ge Road,	Perry H	all, Mary	rland21128
L. Pages 1. ment of He tant. If therr query or oth	20e. Method of Disposition **Deurlel A Crametion 3 Ramova 4 Donetion 5 Other (Specify)	Ce	ece of Disposition (Name metery, crematory or othe arkwood Cer	netery		Baltimon	Town, State re, Maryland
Ball pemit Depart import any in	21. Signaturi of Funeral Service Licensee	Henss)	Burgee-	alls Road	, Balti		e, Inc
Physician /Medical	23a. Parl 1. Entar Indisease, or complications shock, or held failure. List only one ceus Immediate Cause (Final disease or condition	s that caused the death.	C Carcle	r dying, such es cardia	and A	951,	Approximete Intervel Between Onsat and Deeth
Examiner è	resulting in deeth)	Due to (or	es e consequence of):	banto	4500		
ortificate be executed ding physician and se as the burial-transit		Due to (or	es e consequence of):				
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of Vital Physician: The Physician: The ris certificate rial director, pag. To Be Co.;	Hoenite	1:		Other	eth (Check only on		
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Division (- Hospital or Attanding P - Honeal Director: Affect - Honeal Director: Affect - Honeal Director: Affect - Honeal Director: Affect - Honeal Certification:	3 Suicide 6 Could not be determined 28e	Place of Injury - At hor building, etc. (Specify,	me, ferm, street, fectory, o	Hice	28f. Location (St City or Town	treet and Number or Run, State)	urel Route Number,
Hospi 24 hours 19 fil	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or an						
To the within 2 to the mithin 2 to the Med	29b. Signeture and title of certifier	M.D	29g L	Consa number	58 2	9d. Dete signed (Mont	h, Dey, Year)
90	Klumarce Ka	od cause of death (Item	3 Rock S	Spring 1	Road F	orest H	11, MD
State Registrar	31. Date filed (Month, Dey, Year) AUG 2 2 2000	32. Registrar'a Signat	to Apa	Ks			
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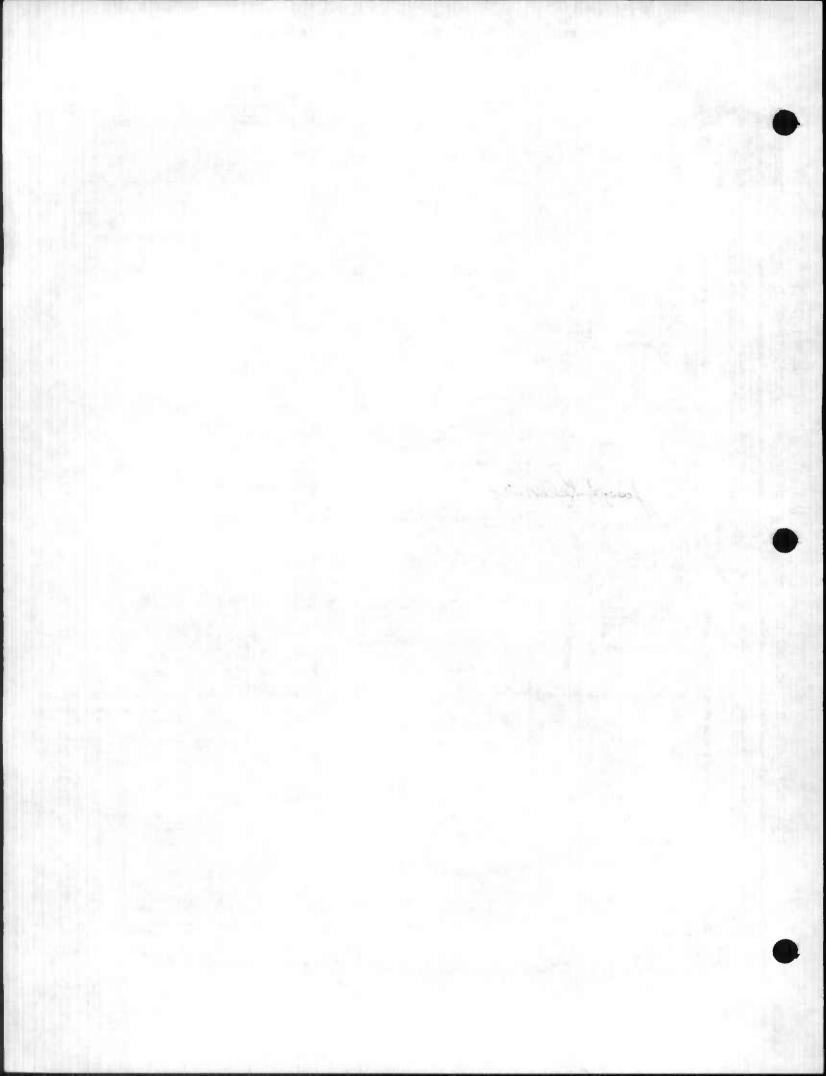


State of Maryland / Department of Health and Mental Hygiene 00 26479

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ORIGINAL

DHMH 16 Rev 6/95



Please Type or Print In Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 16, 2000 **Physician** JAMES WILLIAM KRAUSE 3:00 A.M. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 502 MANSFIELD COURT SEVERNA PARK ANNE ARUNDEL 8. Date of Birth (Month, Day Year) 9. Birthplace (Stet Experiment) 9. Birthplace (Stet MARYLAND) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** Deys Months Hours 306-34-3778 64 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MARYLAND ANNE ARUNDEL 1 Yes 2 No SEVERNA PARK Funeral Director the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? thems 23s or 502 MANSFIELD CT. 21146 UNITED STATES 12. Wes Decedent Ever in U.S. Armed Forces? 1 ₾ Yes 2 □ No If Yes, Give Year or Dates: KOREA Was Decedent of Hispanto Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 1t. Merital Stetus Black, White, etc. filed within 72 hours after 1 Never Married 2 Merried 8 1 ☐ Yes 2 No Specify: 21215-0020 Specify: WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry il Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) GOVERNMENT EMPLOYEE FEDERAL GOVERNMENT Baltimore, Maryland 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be 8 h and Mental WILLIAM KRAUSE PEARL KELLY Pages 1 and 2 should nent of Health and Men 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Nem 27 SONIA JUNE KRAUSE / WIFE 502 MANSFIELD CT., SEVERNA PARK, MD 21146 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition AUG. 20c. Location - City or Town, State 6 1 ☐ Berial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 5 Other (Specify) 2000 CATONSVILLE, MARYLAND 21. Signature of Funera Service Ligensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, 421 CRAIN HWY., S.E., GLEN BURNIE, 21061 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical a. Burkitt's Lymphoma.
Due to (or as a consequence of): Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the inneat director, page 2 should be detected for use as the busin-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes a) No 3 Probably 4 Unknown Completed by 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 27. Mapner of Death 28a. Date of fnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifiq 29c. License number 29d. Date signed (Month, Dey, Year) AUGUST 17, 2000 03595 CARULE of Berson, who composited cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

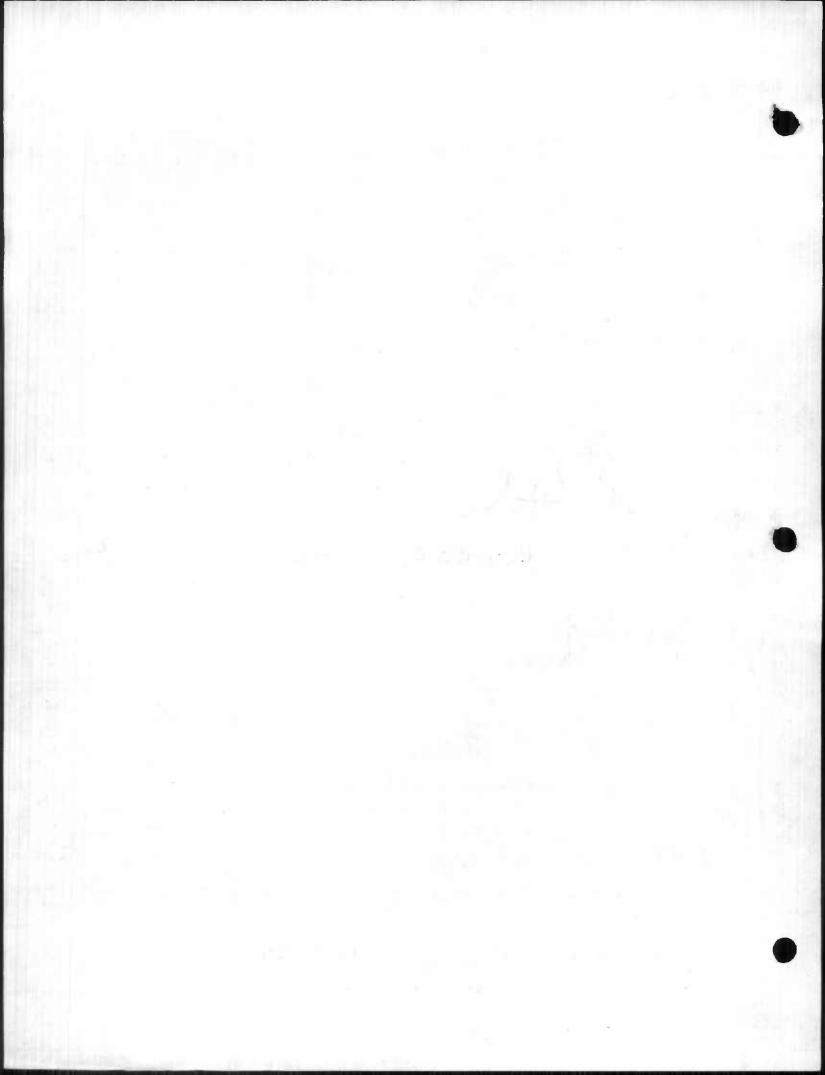
State Registrar

31. Date filed (Month, Day, Year)

京湖市 中 中 安全市 !

32. Registrer's Signature

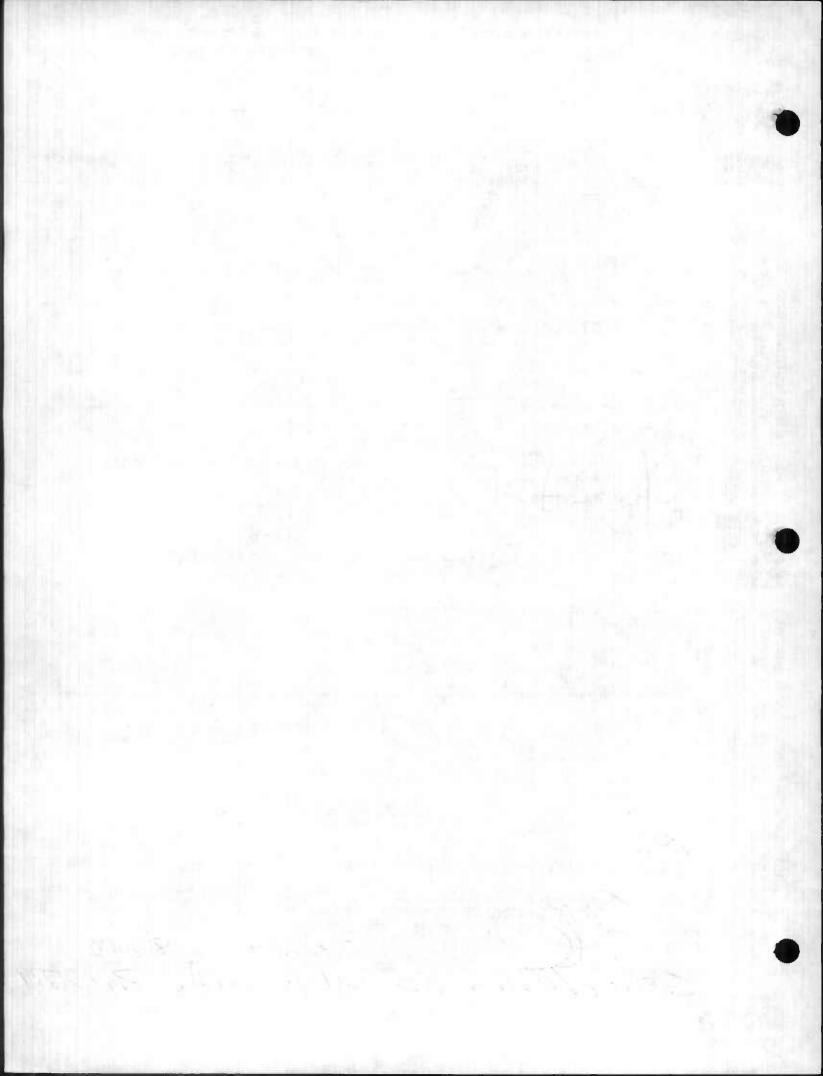
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State of Maryland / Department of Health and Mental Hygiene 00 20101

amend item	m 2	per phys.	G786 8/22/	00 yg		Ce	rtificat	e of	Death		Re	ig. No.	0 4	.6461
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Physicia /Medica		Claren	ce					Kir	sler	d	Oot Aug	0215 O	Year 00	9:00am
Examine		4a Facility Name (If not institution, gl	ve street end numb	er)				4b. City, Town	n, or Loca	tion of Death	4c. County	of Death	
		512 Al	lendale	Road					Balt:					
Funeral Director	2	5. Social Security No. 215-05-3 Usual Residence of	3111	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. 9(last birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Dey, 10 02		Count	ace (State or Foreign ry) • C •
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2 2 2 2 0	1	20a. Method of Dis	position		20b. F	Placa of Dispo	sition (Ne	me of				20c. Location -		vn, State
Pages nent of nrt: If Its rry or o		XLXBurial 2	□ Cremation 3 L 5 □ Other (Speci	Removal from Sta	Art	outus	Mem	ori	al Par	rk 8	/18/00) Arbu	tus,	Md
= = = = = = =	1	21. Signature of Fu	uneral Service Lice	nsee	1	2	2. Name at	nd Addr	ess of Facility		/ 10/ 0		0007	744
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	+	23a Parti Foter t	the disease or con	nplications thet caus	teel the heat							nore M	d 2	1215 Approximete
Physician /Medical Examiner	Jer	Immediate Cause disease or condition resulting in death)	(Final on	· Co	CONJ.	ARY or as a conse	quenca of)	278	æy	De	SEAS	SE		
ificate be axecuted gphysician and as the bunkl-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	enditions, nmediate	b	Due to (o	or as a consec	quenca of)							
	8	that initiated events resulting in death)	s Last	d	Due to (o	r es e consec	quenca of):							
death cert death cert e attendin	Slan												1	FLYELL
E & D	Phys	Part II. Other signif	ficant conditions	contributing to death	but not res	ulting in the u	inderlying (cause g	ven in Part I.		23b. Dld to			the cause of death?
ecords, P.O law requires that the as been signed by th 2 should be detache	Completed by										24a. Was a perform	n autopsy ned?	eva	re autopsy findings iliable prior to npletion of cause death?
7 0 - 2	E										400	8		
ician: The certificate rector, pag		25. Was case refer	red to medical						26 81-	of Dooth	Check or tire		16	Yes 2 No
Or VICAL Physician: T this certificat ral director, p	o Be	examiner?	rred to medical	Hospitai:	atile a C	EDIC .		Ot Ot	hor:		Check only on		10 0	d.
- 7 50	-	1 Yes 227. Menner of Deat		1 Inpe		ER/Outpaties 28b. Time of	-	OA	4 LI NUIS	sing Home		inca 6 Oth)
After fune	5	Natural	5 Pending	(Month,	Dey Year)	Injury	м	28c. Inju Wo	ork?]Yes 2□N		G. D0001100 110	in injury coodin		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not to	28e. Placa of	Injury - At he etc. (Specif	ome, ferm, st			, , , ,		f. Location (St. City or Town		er or Rure	l Route Number,
Hospita 24 hours Funeral		29e. Certifier (Check only one)	Certifying Pl	hysician: To the be	of examine	wledge, deet tion and/or in	h occurred vestigetion	et lhe t	ime, dete end opinion, death	plece, en	d due to the ce at the time, da	euse(s) end ma ate end place,	nner as stand due to	ated the cause(s)
roth comp	2	29b. Signature and	rung dayfi)))			29	c. Licen	se number		2	9d. Date sign	d (Month, L	Dey, Year)
F3F0			17/16	/				T	500	29		81	6/8	O
		30. Name and addr	ress of Marson who	completed cause of	death (Iten	23a) 4Tuno	Print)	11		1		1	7	0
5		PAR	DEV /	87116	AD	MS	2	t/do	0 W	lex	ens Z	Les .	KIS	4 217d
		31. Date filed (Mon	ith, Day, Year)	32 Regi	straps Signe	ture.								, , , ,
State	. I	116 2 2 21	nnn A	enera	19	Anna	2							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** 1:01 ATV August ORP 20 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Baltimore City Samaritan 7. Age (In yrs. last birthday) Ma If Under 1 Ye If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Dete of Birth (Month, Dey, Year) Birthpiace (State or Foreign Country) **Funeral** 10M % F Months Days Hours 90 **Birector** 16 605 DORTH LAROLINA Usual Residence of Deceden 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Directo MARMAND BALTIMORS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA AVS U.S.A. 3808 21206 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes Z No Specify 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Home HONEMAKER 12 Department of Health and Mental Hys Important: If them 27 is marked other any Injury or other traument 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) 86 ResTON JAC JACKSON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21206 19e. Informent's Name/Relationship (Type, Print) BALTIMORE W. BLACK IRAS 3808 20b. Piace of Disposition (Name of cemetery, cremetory or other place) AUG. 22 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removel from State BALTIMORE MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS CHAPILOF 31834 EYANS CHAPILOT ROAD EYANS CHAPILOT ROAD EXAMPLE OF TESTIGO EXAMPLE OF 1ARDAN 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immedieta Cause (Final disease or condition resulting in death) /Medical ears Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as e consequence of): Part Ii. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably Unknown P 24b. Were autopsy tindings eveilable prior to completion of cause of death? Medical Certification: To Be Completed 24a. Was an autopsy page 1 Yes 1 Tyes 25. Was case referred to medice! axaminer? 28. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 1 Inpatient 28a. Dete of Injury (Month, Dey Year) 27. Manner of Dec 28d. Describe how injury occurred 28c. Injury at Work? s after death. N Director: After 1 ed in by the funer 1 BNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License numbe

State Registrar

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attending physician for use as the buna

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Box 68760

P.O.

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Division

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Baltimore, Maryland 21215-0020

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31. Date filed (Month, Day, Year)

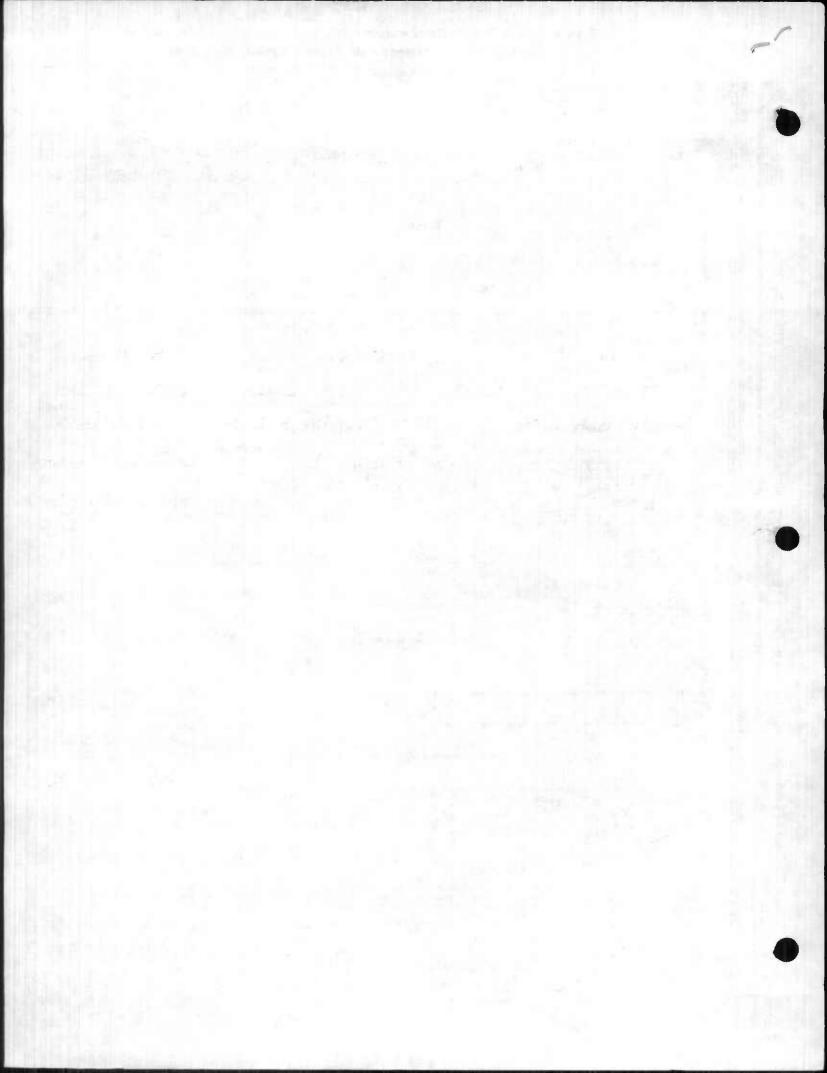
5601 Lock

mpleted ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

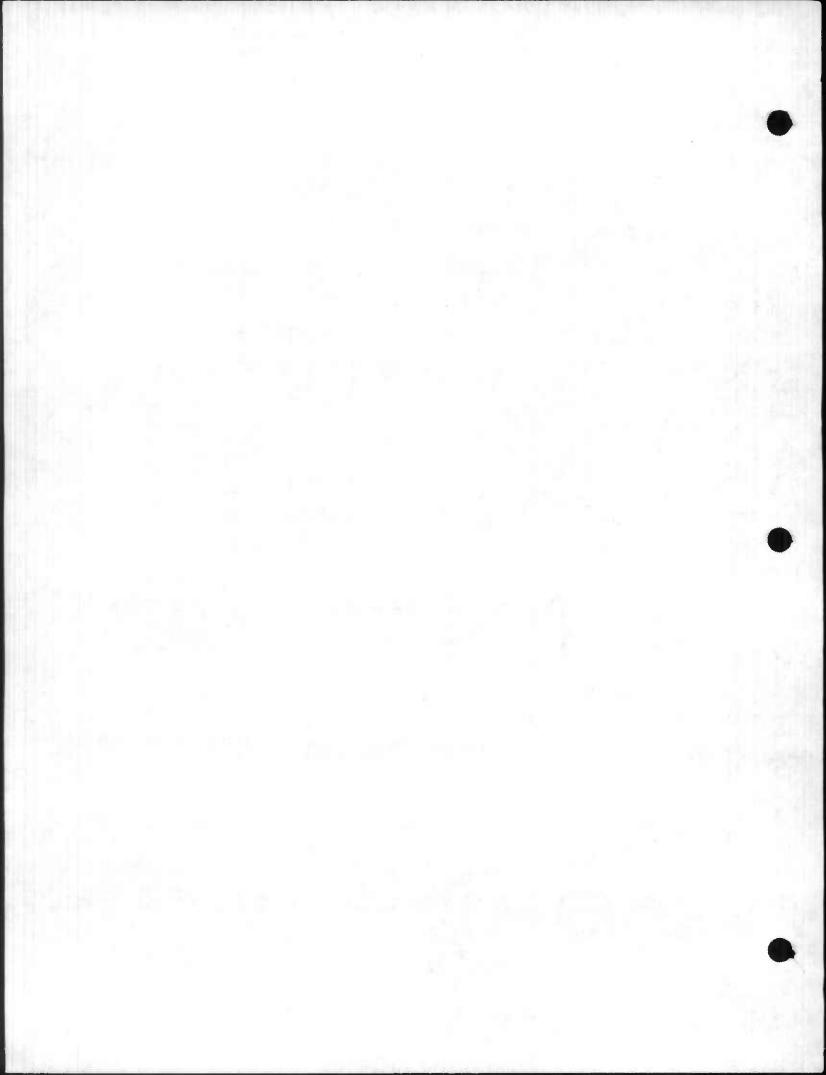
29d. Date signed (Month, Dey, Year)

2000 Baltimore MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						C	ertificat	e of	Death		R	eg. No. 0) 2	6 ls	83
	Physician /Medical	1. Decedent's Name (F	irst, Middle, La	. /	NK						2. Date of Deat	Day to	2,000	3. Time / . 4	of Death
	Examiner	4a Facility Name (If no	t institution, giv	e street end number)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Deeth		
	<u> </u>	Rivervie					i Milada	1 1 1		N/A			Balti		
	Funeral Director	5. Sociat Security Number 234–44–7067. Usual Residence of De	7 1	ex 7. A	ge (In yrs. last	Yrs.	Months	Days	Hours	Min.	B. Date of Birth (Month, Day, Jan 9,1	Year) 915	9. Birthpla Countr Mar	ylan	or Foreign d
	yland		b. County		10c. City, To	own or	Location						10	d. Inside	City Limits
	death with the Maryland me 23e or 28e-f ehow Louet be notified at neral Director	Maryland	N/2	A	Bal	tim	ore							1 🔀 Ye	s 2 No
	or 20	10e. Street and Number	r				10f. Zlp	Code			1	0g. Citizen of V	What Countr	y?	
	ath w	1053 Horne	ers Lane			-	144	2120		-1-0 (0	-'6. V A1-		S.A.	a ladian	-
5-0020	or he	3 ₩ Widowed 4 □		12. Was Deceden Armed Forces 1 Yes 2 H If Yes, Give Year or Dates	? I No	13	3. Was Dece if Yes, spe			gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)		e - America ck, White, et /:		
5-0	72 ho	15 (Specify of	Decedent's Ed	ducation ide completed)	10	(Gi	edent's Usu	rk done	during mos	t of workii		16b. Kind of Bu	usiness/Indu	stry	
121	a filed within 72 hours other than "natural", vent, the Medical Exitem.	Elementary/Seconda		College (1-4or	5+)	life	. DO NOT u	se retire	d)			0			
d 21	s i and 2 should be flied within If Health and Mental Hygiene. Item 27 is marked other than other traumatic avent, the Me		st. Middle, Last.	N/A			Housew	nie	18. Mothe	er's Name	(First, Middle, I		Home		
Maryland	Mental H Mental H arked out attc aver				Hai	nes			Ros	sie			Th	omas	
ary	2 should be and Menta in marked sumatic av	19e. Informent's Neme	/Reletionship (Type, Print)	1	9b. Me	iling Address	s (Street	and Number	er or Rura	l Route Number	City or Town,			
Z	1 and 2 s Haalth ar em 27 ia other trau	William Ho	olmes (S	Son)		105	3 Horn	ers	Lane	Balt	imore,	Marylan	nd 212	05	
ore	of Haalth of Haalth Hern 27 r other tr	20a. Method of Disposi		Removal from Stet	ceme	of Dis	position (Na	me of other pia	ce)		Dete	20c. Location -	City or Tow	m, State	
Ē	Pages nent of ant: If the ury or o	4 Donation 5			Glen	На	ven Me	mor:	ial Pa	rk 8	/21/00	Glen Bu	rnie,	Mar	yland
Baltimore	Department Department Important: I any injury o	21. Signeture of Funer	al Service Licer	nsee		1		y-Po	olynia	ik Fu	neral H			2112	2
		23a. Part. Enter the contact, or heart fe	lisease, or com	plicetions that cause	ed the deeth. E	o not e	3204 M	de of dyi	ng, such as	cardiac o	Pasaden r respiretory arr	est,		Approxim Interval B	ate
	Physician	and the state of	mare. Cist only	-		-	-		1					Onset and	d Death
188	/Medical Examiner	Immediate Cause (Findisease or condition	el	. ROSE	ruste	ne	1 4	au	luce	1				lear	8
п		resulting in death)			Due to (or as	a cons	quenca of)	:						4	
	nine and			b. Pau	elle	oi	iea						12	ha	week
_	icate be assecuted physician and s the buriet-transit edical Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or injuthet initieted events	ions, diate		Due to (or as	e cons	equenca ot)	•					1	gue!	week
68760,	tificate be assect g physician and as the buriel-fra		ny K	C	Due to (or as	a cons	equence of):						1		
Box 68	E 0 4	resulting in death) Last	l	d	500 10 (01 83	4 00113	equence or,								
	iras that the death cer signed by the attandin d be detached for use d by Physician/N	Part II. Other significan	nt conditions o	ontributing to death	but not resultin	g in the	underlying	cause gi	ven in Part I	l.	23b. Did to	bacco use co	ntributs to	the caus	s of death?
P.0	t by the										1 U Y	88 2 No	3 Prob	ably 4	Unknown
Ś	bed by												T		
Record	aw requisite been 2 should									_	24a. Was a perform		ava	re autops: ilable prion opletion o leath?	sy findings or to of cause
E E	The law tate has to page 2 s	2									1 🗆 Y	s 2 No	10	Yes 2	P (No
Vital	ysician: The scentificata director, pag		to medical						26. Place	of Death	(Check only or	(e)			
of V	7 00	1 ☐ Yes 2 No		Hospitel: 1 Inpai	tient 2 ER	Outpet	ient 3 D	OA Ot	her: 4 Dan		me 5 Reside)	
n o	Afrar tl funera	27. Menner of Death	Pending	28a. Date of to (Month, D	ey Yesr) 28	b. Time Injury	/		rk?		28d. Describe h	ow injury occur	red		
Division	Attender death octor: by the	2 Accident 3 Suicide 4 Homicide	investigetion Could not be determined	e 28e. Place of I	njury - At home etc. (Specify)	, ferm,	street, tactor		Yes 2		28f. Location (S City or Town	treet and Numi n, Stete)	ber or Rural	Route N	um <i>ber</i> ,
	To the Hospital or within 24 hours after To the Funeral Dir completaly filled in Medical Cert	29e. Certifier 1 (Check only 2 one)	Certifying Ph Medical Exam	ysician: To the bes niner: On the basis end manner:	of examinetion	ige, de and/or	eth occurred investigation	at the ti	me, date en opinion, dea	d place, e	end due to the c ed at the time, d	euse(s) and m ete and place,	anner es sta end due to	ited. the ceuse	B(S)
	To the comple	29b. Signature end title	of certifier	K. To	pu	au	29	C. Licens	30 6	361	2	Date signe	d (Month, C	Pay, Yest	2000
	S	30. Name and address	of person who	completed cause of	death (Item 23	a) (Typ	e, Print) S	rea	eest	21	RIPUR	ANG	NI		
	State Registrar	31. Date filed (Month, L	AÚG'2	2 2000 Regis	trar's Signature	مه	B	de	ants						

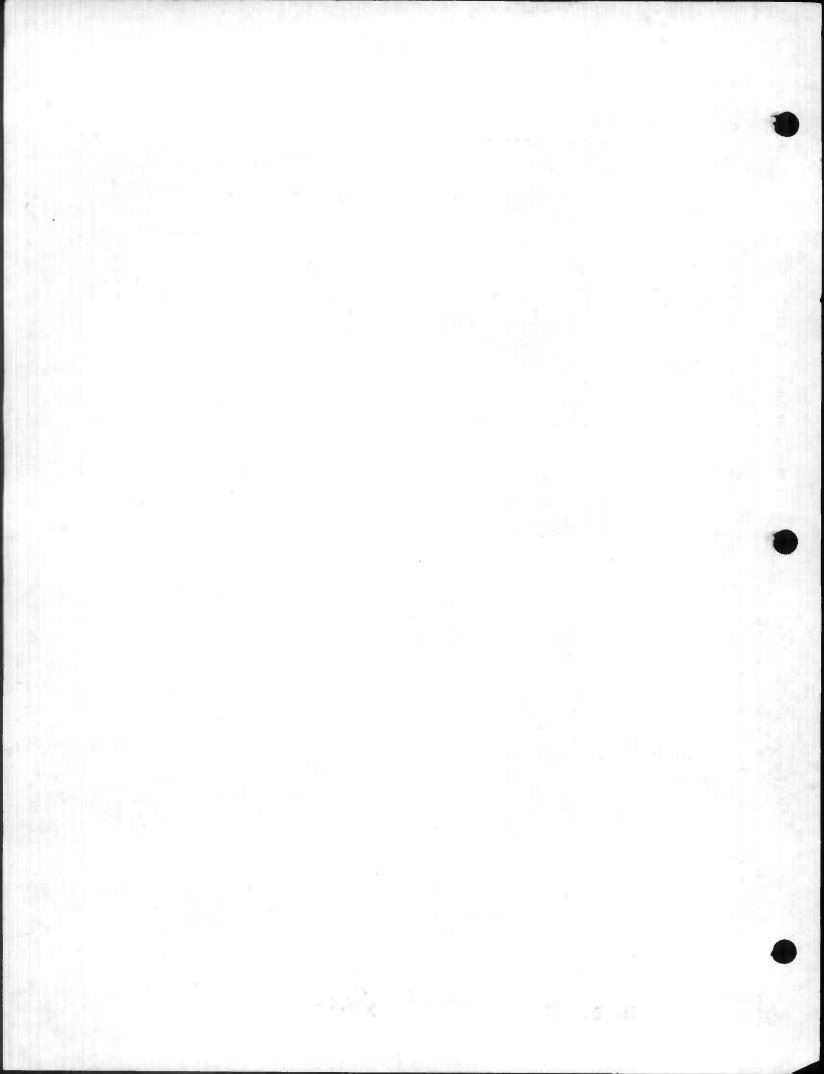


Patrick Anthony Long

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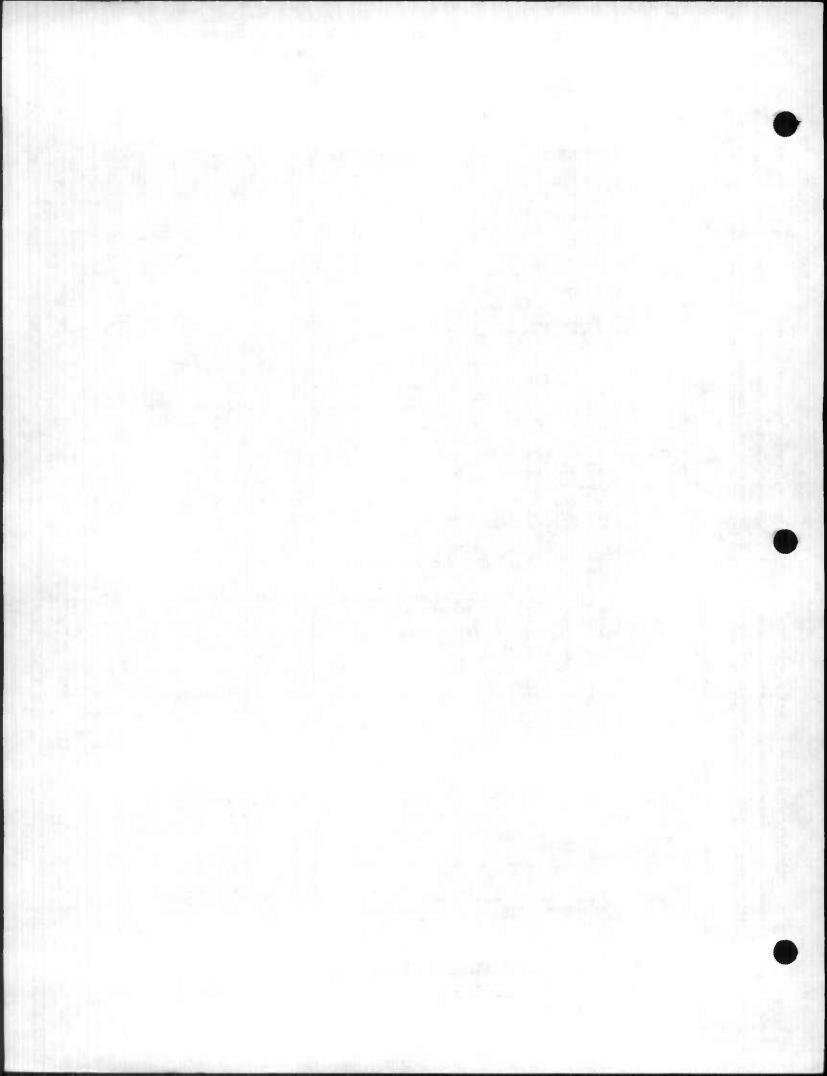
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	State of Mandand	/ Department of H	acith and Mar	stal Hygiana	

	AMEND	ΙT	EMS: #23 PART	I, 27, P	ER ME	Cel	dificate of	Death WR	•	Reg. No.	0 26484
	Physicia /Medic	_	Decedent's Neme (First, Middle, L PATRICK A	NTHONY	LON	G			2. Dete of De Month August	Day	3. Time of Death 900 04:00 P.M.
5	Examin	_	4a Facility Neme (If not institution, gi	ve street and number)				4b. City, Town, or L	ocation of Deeth	4c. County o	f Death
				Arundel Ho	-		Withdress	Glen Bur		1	Arundel
	Funeral Director		217-56-2744	Sex 1□XM 2□ F	e (In yrs. las	Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, De Aug. 0		Birthplace (State or Foreign Country) Maryland
	aryland ahow		Usuel Residence of Decedent 10a. Stete 10b. County	. 1 1 0	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Med a	Director	PIU.	undel Co.	Pa	saden	1				1 ☐ Yas 2 ☒ No
	Jeath with the Marylan ma 23a or 28a-f ahow mat be notified at		10e. Street and Number 3503 D Dave	nport Cour	t		10f. Zip Code	21122			USA
020	ors after of the	by Funeral	11. Merital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 1 Yes, Give Yeer or Detes:			Wes Decedent of H f Yes, specify Cub.	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		- American Indian, , White, etc. white
21215-0020	within 72 hours lene. than "natural", ne Medicel Ex-	Completed	15. Decedent's E (Specify only highest gi Elementery/Secondery (0-12)		5+)	(Give	dent's Usuel Occup kind of work done DO NOT use retired il Servat	during most of work d)	ing	16b. Kind of Bus	. Government
	モエもを		17. Father's Neme (First, Middle, Las					18. Mother's Nem	e (First, Middle,	Maiden Surneme))
Maryland	200	o Be	Hubert F. Long					Joan	n D. Ri	ley	
ary	# DEE	-	19e. Informent's Neme/Reletionship	(Type, Print)				end Number or Rui			
	and alth		Druscilla L. Bu	rke (Siste	r)	734	Larue Ro	oad, Mill	ersvill	e, Md. 2	1108
Baltimore,	20 70		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Content of the Content		cen	netery, crer	sition (Neme of netory or other ple unt Ceme		Dete 21/2000		ore, Md.
Bait	permit. Pag Department Important: I any Injury o		21. Signature of Fundral Service Lice	nsee Kevin E	cker	M		es of Fecility Olyniak F tain Road			
			23a. Pert1. Enter the diseese, or cor shock, or heert failure. List only	nplications that caused	the deeth.						Approximete Intervel Between
	Physician /Medical		Immediate Ceuse (Final			-					Onset and Death
	Examiner		disease or condition resulting in deeth)	а				IOVASCU	LAK DI	SEASE	
		Jer			Due to (or e	es e conseq	quence ot):				
o,	icate be executed physician and s the buriet-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or a	as e conseq	quenca of):				
x 68760,	ficate physics the	VMedical	Ceuse (Diseese or injury that initiated events resulting In deeth) Last	d	Due to (or e	es a conseq	uence of):				
Box.	death certi	Ciar	Part It. Other significant conditions	contributing to death h	ut not recult	ing in the u	ndarh/ing cause ni	en in Pert I	23h Did	tohacco usa con	tribute to the cause of death?
P.0	that the ed by th detache	by Physician/M	Tatti. Other algimeans continue	contributing to death o	ut not result	ang in the d	ilderlying cause gi	on air eiti.			3 □ Probably 4 □ Unknown
Vital Records,		Completed b								an eutopsy ormed?	24b. Were eutopsy findings availeble prior to completion of cause of deeth?
E .	The la	200							18	Yes 2□No	1 ☐ Yes 2 ☐ No
/Ita	certificate rector, par	Be	25. Was case referred to medicat axeminer?					26. Plece of Dee	th (Check only	one)	
of	hys light	2	1. Yes 2 No	Hospitel:			II JU DOA			denca 6 Othe	1-1
	ding P. th. After t	tlon:	27. Manner of Death 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident Investigetic	28e. Dete of Inju (Month, De	y Year) 2	8b. Time of Injury	Wo	ryet rk? Yes 2 □ No	28d. Describe	how injury occurre	ed
Division	if or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not determined		ury - At hom c. (Specify)	ne, farm, str	reet, fectory, office		281. Location (City or To	Street and Numbe wn, State)	er or Rurel Route Number,
		edical C		hysician: To the best miner: On the basis of end menner ste	examinetio						nner as stated. and due to the ceuse(s)
	To the comp		29b. Signature end title of cartifier	1 0/ -	11/4	(1)	29c. Licens	se number		29d. Date signed	(Month, Day, Year)
•			30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type,		C.M.E.		Augus	t 19, 2000
			MARLBAITS B	KOREL	(111 P	enn Stre	et, Balti	more, M	aryland	21201
	Stat Registra	e ir	31. Dete filed (Month, Dey, Year) AUG 2 2 20	32 Aggisty	ar's Signetu	. B.	Sparks	1			



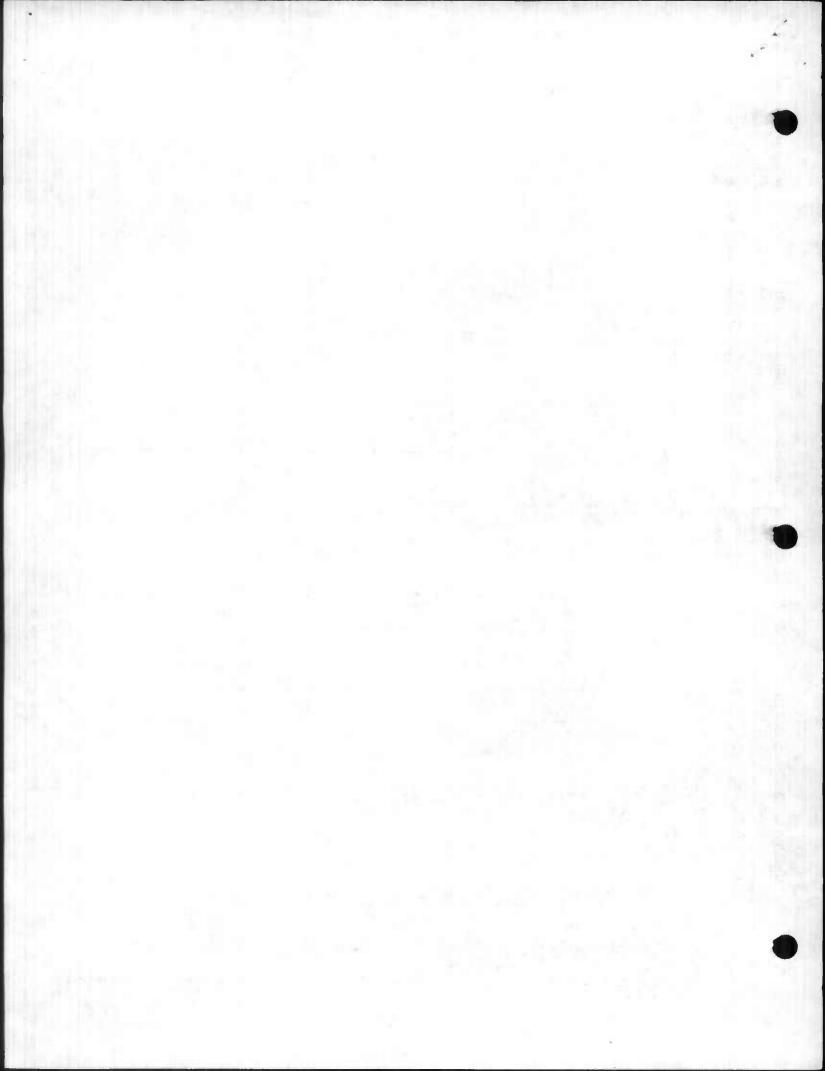
State of Maryland / Department of Health and Mental Hygiene

									Death		Reg. No.) (6465		
Ph	nysician	1. Decedent's Name (First, Middle, Last) Pouline Legum 4a Facility Name (If not institution, give street and number) 4b. City, Town, or L								2. Date of De Month	Day Day	Year	3. Time of Death		
1	Medical									August 18 2000			6:50 PM		
E	xaminer	AT ALL A THE PANTONI													
F		5. Social Security Number	6. Sax	pital	Centel	last birthdey)		r 1 Year	If Under 24 Hrs.	8. Date of Bir	h	9. Birthp	lace (State or Foleign		
	neral ector	220-50-3564 1 M 27 F 89 Yrs. Months Days Hours Min. Month, Dev Year 1910 NEW YO											YORK		
and **		Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. In										Od. Inside City Limits			
020 hurs after death with the Manylar alf, or items 23s or 28s-f show	tor	MD BALT	IMORE		BALTIMORE						1 □ Yes				
	Director	10e. Street and Number		10f. Zip Code						100			g. Citizen of What Country?		
ith wi	23a	2331 OLD COUR		21208					USA						
15-0 72 hc	funeral	11. Marital Status	1	12. Was Decedent Ever in U.S Armed Forcas?			,S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert			pecify Yas or No o Rican, atc.)	- 14. Race Black	14. Race - American Indian, Black, Whita, etc. Specify: WHITE 16b. Kind of Business/Industry			
	by F	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		1 ☐ Yes 2 If Yes, Give Year or Da	1 ☐ Yes 2 No Specify			Specify:	pecify:						
	te d	15. Dec	cation	16a. Deced	16a. Decedent's Usual Occupation (Giva kind of work done during most of wo			ting	16b. Kind of Bu						
		(Specify only h	life. L	DO NOT	se retin	ed)	King								
A 5"	Comp	12				HOMEMAKER			18. Mother's Name (First, Mi		OWN HOM				
5 8 E 8	avant, Be C	17. Father's Neme (First, Mic	ddle, Last)			RUBIN				ne (First, Middle,	Meiden Sumem				
should be	To To		HARRY 19a. Informant's Name/Reletionship (Type, Print)					- (Ctons	MINNIE	and Davida Mumb	Code				
2 0 8 8	3	DR.RONALD LEG								ral Route Number, City or Town, State, Zip Code) W AVE.SEDGWICK, MAINE 04676					
or 1 and of Health	other traumatic	20e. Method of Disposition	0.17		20b.	Place of Dispo	sition (Ne	me of		Date	20c. Location -				
0 0 0	8	1 ☑ Burial 2 ☐ Crema 4 ☐ Donation /5 ☐ Oth		3 Removal from State cemetery, crametory or other place)							8/20/00 OWINGS MILLS, MD.				
	Injury	21. Signature of aperal Se	- 61	0						-					
Balt permit. Departr	S S S S S S S S S S S S S S S S S S S	1 Jayre	22. Nama and Address of Facility SOL LEVINSON & BROWN 8900 REISTERSTOWN ROAD PIKESVILLE, 1												
		23a. Part1. I yer the diseas shock, heart failure.	a, or complic	cations that ca e cause on ea	used the dear	th. Do not ente	er the mo	de of dy	ing, such as cardiac	or respiratory a	rrast,		Approximate Interval Between		
Physi		Onset and Death													
/Med Exam	_	Immediate Causa (Final disease or condition resulting in deeth)	a	Multi	plec	man	Syst	em	failure			11	2 hours		
		rossing in doorly			Due to (or as a conseq	uerice of)	:		1		1			
. Box 68760, death certificate be assected e attending physician and of or use as the burial-transit	ial-transit Examiner		. Systemic inflammatory response syn								ne	>	24 hours		
	EXS	Sequentially list conditions, Due to (or as a consequence of): / if any, leading to immediate										1	14		
68760, ficate be av	s the burial edical Ex	Cause (Disease or Injury that initiated events	C.	Acute		emiou	uence of):						2 months		
68 riffica		resulting in death) Last	sutting in death) Last												
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D. E.	sic.	Part II. Other significant con	nditione cont	contributing to death but not resulting in the underlying cause given in Part I.						23b. Dld	23b. Did tobecco use contribute to the cause				
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	2 2	CONTINUE OF THE PROPERTY OF TH								04-144	24e. Was an eutopsy 24b. Were autopsy fir				
of Vital Records Physician: The law requires this certificate has been sign	page 2 should	Hypertension								performed? available prior completion of of deeth?					
Rec law	mpi														
	S S												Yes 2 No		
of Vital Rec Physician: The law this certificate has b	irector 5 Be	25. Was case referred to me axaminer? 1 Yes 2 No		Hospital:											
	- H	27. Mariner of Death		28a. Dete of	Injury	28b. Time of	28b. Time of 28c. In				how injury occurr		Y)		
	e fune		ending vestigetion	(Month	, Dey Year)	Injury	М		ork?]Yas 2 ☐ No						
VIS Atter	by the	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Placa o	of Injury - At h						281. Location (Street and Number or Rural Route Number, City or Town, State)				
D Pario	led in by the funera Certification:		building, etc. (Specify)									ony or rown, state)			
Division To the Hospital or Attending within 24 hours after death To the Funeral Director: Afte	Completely filled Medical Ce	29a. Certifier 1 Certifier (Check only one)	tifying Physi Ical Examin	er: On the bas	sis of examina	owledge, death ation and/or inv	occurred	at the t	ime, dete end plece opinion, death occu	, end due to the irred at the time,	cause(s) and ma date and place, a	nner as si and due to	tated. the cause(s)		
ithin it	Med	one) and manner stated. 29b. Signatura and fitte of certifier 29d. Data signed (Month, Day, Year)													
FEF	N	1 Bosto	18		D 28462					August 18 2000					
Son											nagasi 10, 2000				
de		J Bost	A.1	arthu	ect Lle	n Dita	(p)	nto	Rando	Ilctorin	Maryl	and			
	State	31. Date filed (Month, Day,	(e) 0 20	A	gistrar's Sign		9	Ano	W/A	VII OW	Mary				
D.	adietrar	AUla	446	ש ווענ	A Property	/		200	Child country						



AMENIDED TO	EMC #20ba	DED EU 0794 0	State of						ind M		giene O	0	26486		
Physician	MS #20b-c PER FH G786 8/22/00 AH 1. Decedent's Name (First, Middle, Last) John T. Linster, Jr.								2. Date of De	1109.110.					
/Medica Examine	4a Facility Name (If not institution, give street end number) Genesis Elder Care-Loch Raven 4b. City, Town, or Loc Parkville									cation of Death					
Funeral Director		5. Social Security Number 222-16-8718 8. Sex 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1			Age (In yrs. lest birthdey) 69 Yrs. If Under 1 Yea Months Days				s Hours Min. (Month, I			Birth 9. Birthpl Count 13, 1930 Mary			
show dist	10a. State										10d. Inside City Limits				
or 28a-f	MD 10a. Street and 8313 N	MD Baltimore 10a. Street and Number 8313 Nunley Drive Apt D					Code 234				1 □ Yes 2 ☑ 10g. Citizen of What Country? U.S.A.				
(20 rt after death w raminer must b	11. Marital State	11. Marital Status 12. Was Decedent Ever Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give 5 Orgen or Detes:				n U.S. 13. Was Decedent of Hispenic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricans 1 □ Yes 2 ॲNo Specify:						or No- 14. Reca - American Indien, Black, White, etc. Specify: White			
21215-0020 ad within 72 hours at yelene. or than "catural, or the Medical Exam Commission hours	7	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				dent's Usu kind of w DO NOT	during most t)	of working	ng	16b. Kind of Business/Industry State of Maryland					
Maryland 2 d 2 should be fined of the smarked other of treatmentic event, its T. B. T. B. T. B. C.	17. Father's Na	17. Father's Name (First, Middle, Last) John T. Linster, Sr								e (First, Middle, Maiden Sumeme) Snyder					
- CHNL		19a. Informant's Name/Relationship (Type, Print) Mildred Linster 19b. Mailing Address (Str. 8313 Nunley													
Saltimore, emit. Pages 1 a separtment of He mportant: if them my bijury or other fice.	1 Burial	20e. Method of Disposition 1													
Balti permit. Departrimports any inju	21. Signaturn	21. Signature Funeral Service Licenson GARRISON FOREST VETERANS CEMETERY GARRISON, MD 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Parkville, MD													
Physician /Medical Examiner	Immediate Cau disease or con resulting in dee	232 Part (. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in deeth) Due to (or as e consequence of):													
8760, ste be executed hysician and the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events) Course (Disease or injury thet initiated events)										eukron				
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P.O. het the deby the detached	Part II. Other al	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.									23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
s been si						24e. Wes	erformed?		ere autopsy findings vailable prior to empletion of cause death?						
- F 80 0		25. Was case referred to medical 26. Place of D										1 Yes 2 No 1 Yes 2 No			
- 2 00	1 Yes	2 No Death 5 Pending	Hospital: 1 Inpatient 2: ER/Outpatient 3 DOA Other: 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Work?						4 VO Nursing Home 5 Li Hesidenca 6 Li Other (3				(5)		
Attentar deat octor: by the	2 Accider 3 Suicider 4 Homici	6 Could not be	28e. Placa o	Be. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)						281. Location (Street and Number or Rural Route Number, City or Town, State)			el Route Number,		
the Hospital or hin 24 hours afte the Funeral Dir nplataty filled in	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as state of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the and manner steted.												stated. o the cause(s)		
To the same of the	29b. Signature	29b. Signature and title of cartifier					29c. License number D 28987					29d. Date signed (Month, Day, Year) 8 - 16 - 00			
State	CARL	30. Name and address of persod who completed cause of death (Item 23a) (Type, Print) CARL SPERLING MD, 5'601 LOCH RAVEN BLVD BALD, MD 21239 31. Date filled (Month, Dey, Year) 32. Registrer's Signature													
Registrar		AUG 2 2 2	2000	AL JUNE	1	1	3000	15-1							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ENDED ITEM #5 PER FH G787 9/6/00 State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #5 PER FH G786 8/22/00 AH Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 12:28 8 Month Dev Year **Physician** miller Hnna 4b. City, Town, or Location of Death 16 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner BS1+imore City I r If Under 24 Hrs. 8. Date of Birth s Hours Min. (Month, Day, Year) Baltimore Center Medical If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours Months 1□M 2 F Yrs. रेगा उरे January 26,19 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location items 23s or 28s-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? T 2508 Anders Rd. 21234 USA death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Merital Status Was Decedent Ever in U,S. Armed Forcas? 14. Rece - American Indian. Bleck, Whita, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Nevar Married 2 Married natural, or altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify by 3√ Widowed 4 Divorced Year or Dates: White

16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Towson Courthouse Clerk 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be Pages 1 and 2 should be nt of Health and Mental 2 Andro Kovalic Anna Petro 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea L. Tracey 420 E. Amberleaf Trail, Westfield, IN 46074 20e. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Steta permit. Pages I Department of H Important: If Ite any Injury or ot phose cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata Aug 19 2000 4 Donation 5 Other (Specify) Parkwood Cemetery Parkville, MD 22. Name end Address of Facility Evans Funeral Chapel 8800 Harford Rd. Parkville. Part I. Enter the disease, or complications that causad tha deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Final @ DITATOIX rres diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Physician/Medical Examiner AMANA AMP that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es e consequence of): 68760 the th Dua to (or es a consequence of): 88 Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Records, by The law requires 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an eutopsy performed? page 2 2 No certificate of Vital Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Date of Injury (Month, Day Year) 27. Megner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Affer Hospital or Attending 1 Neturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after deat 3 Suicida 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) August 16,2000

Registrar

State

30. Nama and agoress of B

31. Dete filed (Month, Day, Year)

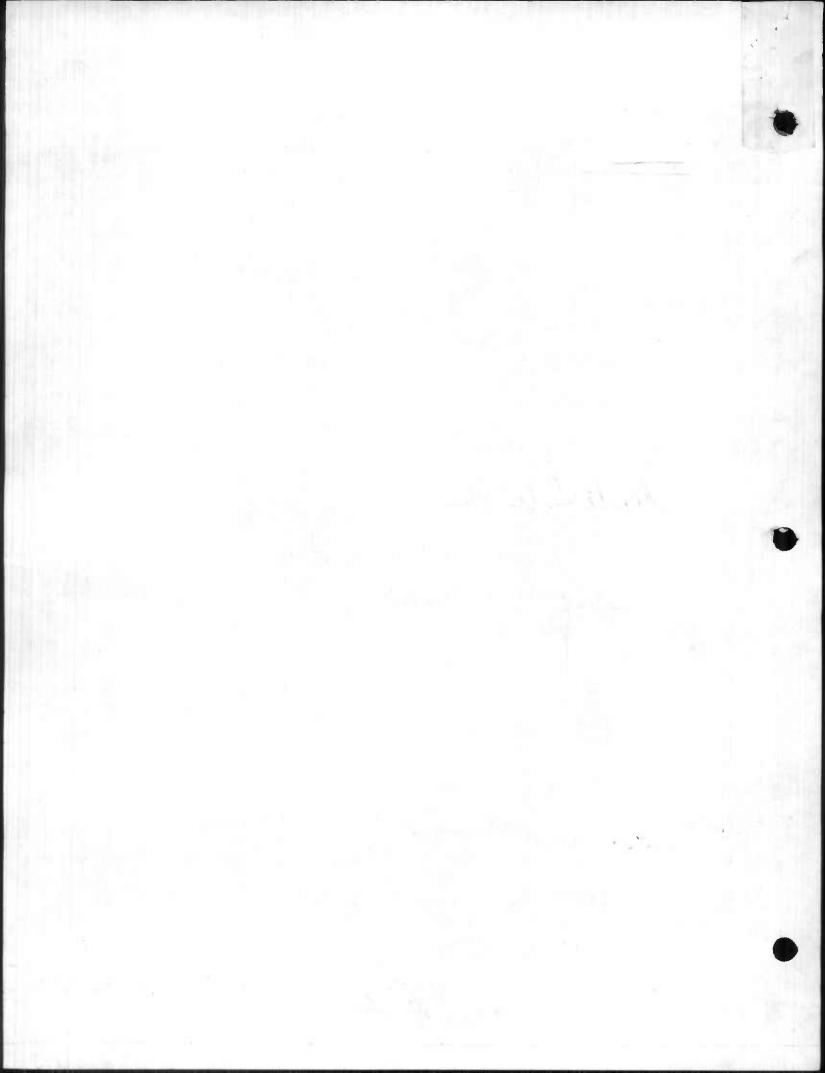
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32. Registrer's Signeture

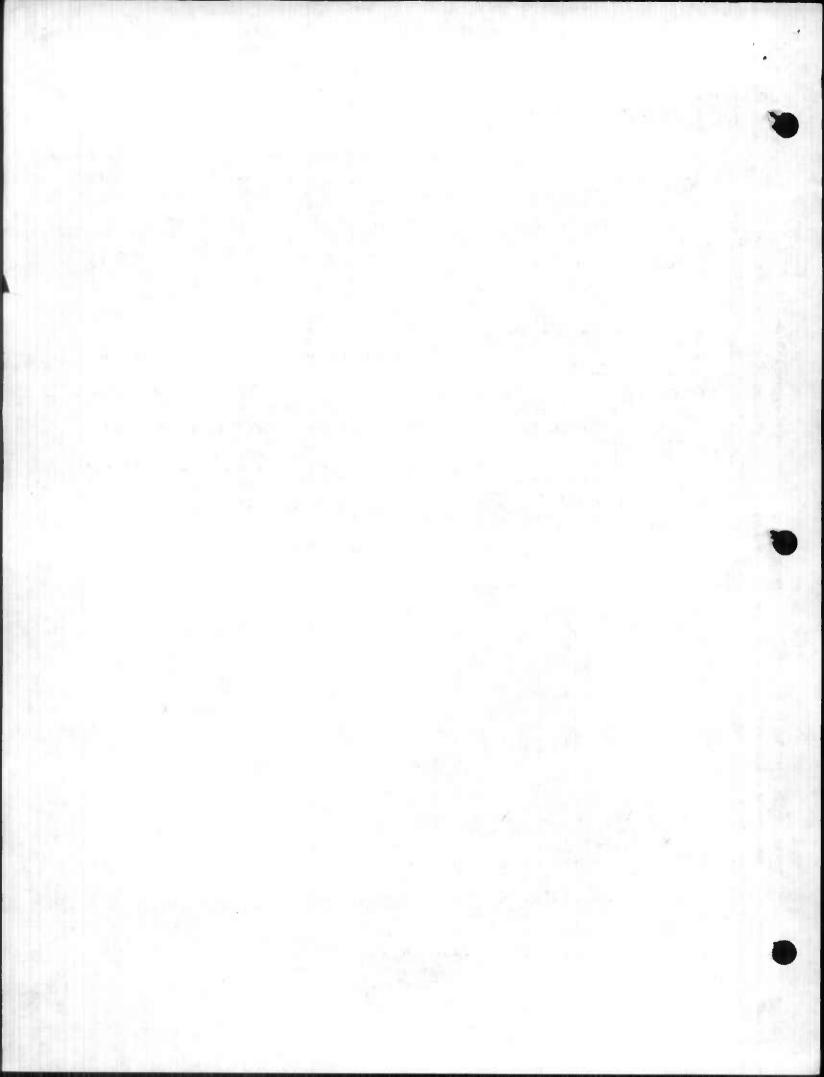
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		State of Maryland	Certifica				giene Reg. No.	261.00	
Physiciai /Medica	D A C C TO A	NAE MADI	DEN			2. Date of Dec Month AUGUS	Day	Year 2000 3:45 PM	
Examine	An Charles Alaman 166 and Investment and a		:er	41	City, Town, or L			ofDeath Baltimore	
Funeral Director	212-34-4164	7. Age (In yrs. Ia		ler 1 Year s Deys	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da	y, Year) 1937	9. Birthplece (State or Foreign Country)	
Do B.	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location					10d. inside City Limits	
with the Marylar a or 28a-f show be notified at	MD BALTIME		CKEYSVIL	1-				1 Yas 2 No	
r 28s	M) BALTM!	JRC C		Zip Code			10g. Citizen of V	Vhat Country?	
The State of the Control of the Cont		RD.		210	30			U.S.A.	
lar das	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		cedent of His pecify Cubar 2 No	spanic Orlgin? (Se n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race Blace Specify	e - American Indian, sk, White, etc.	
P Pour	15. Decedent's Edu		16a. Decedent's Us	sual Occupa	tion		16b. Kind of Bu	BLACK usiness/Industry	
21215-0020 d within 72 hours at piens. t then 'netural', or the Medical Exert	(Specify only highest gred Elementery/Secondary (0-12)		life. DO NOT	work done d use retired)		king		LESTIC	
- 2524 ·	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,			
hould b d Ment marked marke	ROBEZT 19a, Informant's Name/Relationship (7)	TYLER	19b. Mailing Addre	nes (Straat a	DOIZO			TITEWS State Zin Code)	
Man Man	BENEST C. MADDEN		2.100					21030	
Pe 1 at other other	20a. Method of Disposition	20b. Pla	ace of Disposition (A metery, cremetory o	leme of	a)	Date		City or Town, State	
Pages 1 ent of He mt. if New ry or oth	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Hemoval from State	TARRISON	FORES	T	1000 JOOO	(-A1781	SON, MO.	
alti partir pat partir partir partir partir partir partir partir partir partir	21. Signeture of Funeral Service Licen	YE		and Addres	4	IANS FUA			
m falls	Jasn 24	7.7	1215	- UN	K RD.				
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8760, cate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury	Due to (or	as a consequence of	f):					
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Records, P to lew requires that that been signed b the Should be determined by							an autopsy med?	24b. Were eutopsy findings available prior to completion of cause of death?	
C 2 5 5						10	res 2 No	1 □ Yes 2 No	
Vital Decentificate irector, per	25. Was cese referred to medicel				26. Plece of Dee				
	1 TYes 2 No	Hospital: 1 inpatient 2 □ E	ER/Outpatient 3	DOA Othe	vr.	ome 5 Resi		er (Specify)	
Attending Physic deeth.		28a. Date of Injury (Month, Dey Year)	28b. Time of tnjury M	28c. Injury Work	at ? ∕es 2 □ No	28d. Describe	now Injury occur	red	
	3 SuicIde 6 Could not be determined	28e. Place of injury · At hor building, etc. (Specify)	me, farm, street, fact	ory, office		28f. Location (City or Tou		per or Rural Route Number,	
Hospit 14 hours Funer tely fill	29a. Certifier To Certifying Phy	elclan: To the best of my know iner: On the basis of examination and manner stated.							
of the state of th	29b. Signature and litle of certifier			29c. License	number		29d. Date signe	d (Month, Dey, Year)	
1/	· naturidad	D. de feor	, m. s.	D 195	808		8/15	100	
ME	30. Name and address of person who con NATIVIDAD D. d.	ompleted cause of death (Item :	23a) (Type, Print)	SLER	DRIVE	TOWSON,	MARYL	AND 21204	
State Registra	31. Date filed (Month, Day, Year)	2 2000 Alexander	ure B	pp	racks				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 17, 2000 6:53pm Antonio J. Mosca 4c. County of Death Baltimore 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth Long Green 12820 Long Green Pike 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1₹DM 2□ F Months Days Hours 216-16-9315 76 Yrs. 1924 Maryland May 30, Usual Residence of Decedent 10a State 10h. County 10c City Town or Location t 0d. Inside City Limits Baltimore Parkville 1 Yes 2€ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2809 B Kings Ridge Rd. 21234 USA 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Elementery/Secondary (0-12) College (1-4or 5+) Brick laver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Mosca Frances Surrentino 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Helen Mosca 2809 B Kings Ridge Rd., Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug 21 2000 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery Rosedale, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Pa Parkville, MD Approximate Interval Between Onset and Deeth Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of seath? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) \ \(\Omega\) \(\Omega\) \ \(\Omega\) \\(\Omega\) Yes 2€ No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury

Examiner sicien and burial-transit physicien Physician/Medical the signed by det þ Completed certificate hes page Physicisn: Be 10 this Medical Certification: After

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items 23a

"natural", or

1 and 2 should be filed within 7 Health and Mental Hygiene.

Health I

Department of He Important: If Nen any Injury or oth once.

Physician

/Medical Examiner MD

Director

Funeral

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Completed

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the Meryland

72 hours efter

Baltimore, Maryland 21215-0020

68760 Box P.O. Records, of Vital Division or Attending after death.
Director: Aft
d in by the fur To the Hospital within 24 hours a To the Funerel D

State

DHMH 16 Rav 6/95

2 Accident 3 Suicide

4 | Homicide

29b. Signature and title of og

31. Date filed (Month, Day, Year)

29a, Certifier

Registrar

AUG 2 2 2000 225 2 2 A661

of person who

KODER

6 Could not be

SC Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Blvd.

ORIGINAL

Loch

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

eause of deeth (Item 23e) (Type, Print)

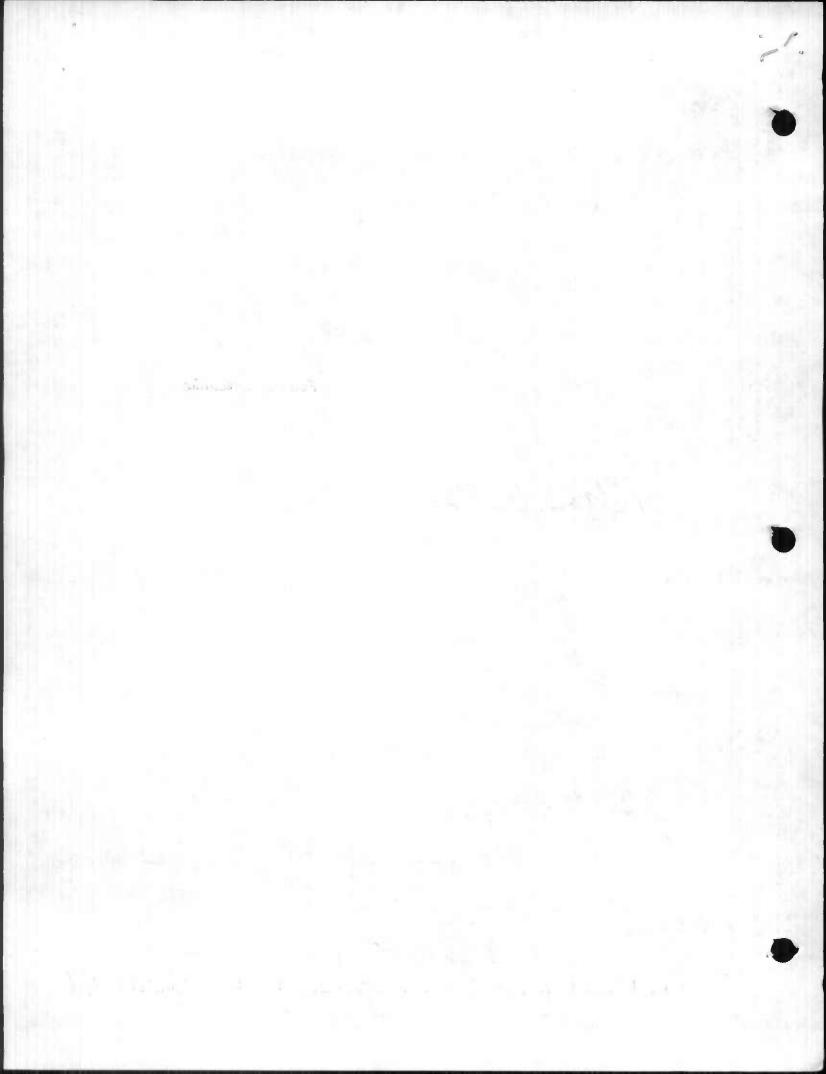
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and manner stated.

SIGO

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AUGUST JOHN MORGAN NESLEY 0153 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOS PITAL HAZFON O FALLSTON ER FALLSTON GENERAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) DEM 20 F Months Days Hours Yrs. 218 42 8550 12008555 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2KQ No MARYLAGO HARFORD ARLinblor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KOAD .A 4104-16 odniwono 21034 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Detes: Black, White, etc. 1 ☐ Never Married 3 € Merried 1 Yes 21 No Specify: STIHW 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPPORT 12YRS ayrs. MANAGER WAL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) HOPE ORGAN KUBY BINACI 15.5 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4104-16 COOWING ROAD DARLINGTON, State

And of Disposition (Name of Dete 20c. Location - City or Town, State TERESA MAE ORGA6 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2000 FORST HILL 22. Name and Address of Facility CHAPIL - BUL AIR, P. A! EVAN FUNERAL CHAPIL - BUL AIR, P. A! 3 NEW PORT ORIVE FOREST HILL ME 21. Signature of Funeral Service Lidensee 21050 MARILAND 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Finat disease or condition resulting in death) LEVICEM 14 ALUTE LYMPHATIL Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of douth? 1 Yes 2⊠ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Ves 2 No 1 Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 DK R/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

Division of Vital Records, P.O. Bo
To the Hospital or Attending Physician: The law requires that the death of within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attent completate they the turners director. page 2 should be delathed for us

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To the Hospital
within 24 hours
within 24 hours
To the Funeral
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Certification:

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be filed within 72 hours after tal Hygiens. d other than "natural", or IN event, the Medical Examin

Department of Heath and Abouid be file important: if New 27 is marked other any injury or other traumatic accept 2003s.

Physician /Medical

21215-0020

Maryland

Baltimore,

/Medical

tate
31. Date filed (Month, Day, Year)

AUG 2 2 2000

290. Signature and title of certifier

32. Registrar's Signeture

and address of person who completed cause of deeth (Item 23a) (Type, Print)

BEZAN MO

29c. License number

OCME

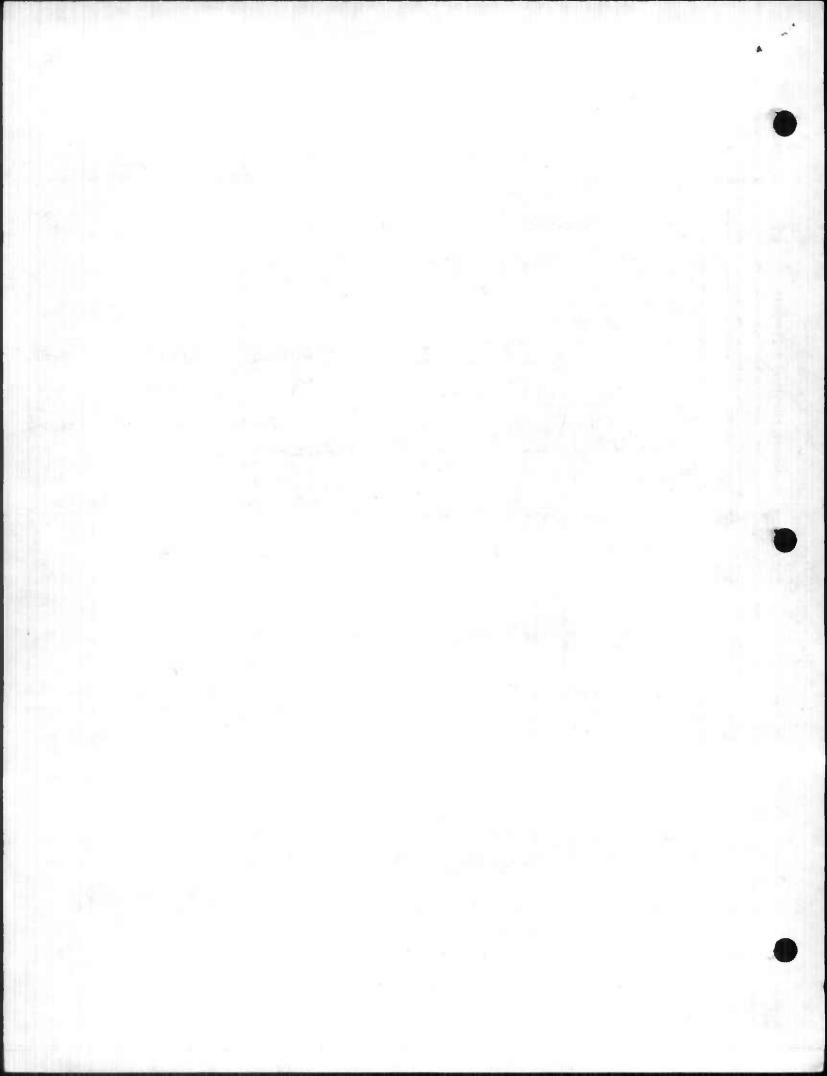
29d. Date signed (Month, Day, Year)

BOLAIR 71 21014

17,2000

DHMH 16 Rev 6/95

DME



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2649 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Physician 4:21 PM George Mayo, \overline{V} 20, 2000 August /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 921 Upper Glencoe Road Glencoe Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 1 M 2 □ F Yrs. Director 212-26-1621 Oct 24, 1928 Maryland **Usual Residence of Decedent** death with the Maryland 10b. County 10c. City, Town or Location Show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours eftar death with the Maryle nant of Health and Mentel Hyglene.
Int: If Nem 27 Is marked other than "natural", or Nems 23s or 23s-f show any or other treumsite event, the Medical Examina must be notified. 1 ☐ Yes 2 ☑ No Director Baltimore Glencoe Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 921 Upper Glencoe Road 21152 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, etc. 1 ☐ Never Married 2 Married 1 ☐ Yas 2 ☒ No If Yas, Give 21215-0020 1 ☐ Yas 2 ☑ No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Yaar or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bualness/Industry The Middleton & Elementary/Secondary (0-12) College (1-4or 5+) 12 President & CEO Meads Co., Inc. n/a Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Mayo, IV George Edith Germaine Gorsuch 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 921 Upper Glencoe Road, Sparks, MD 21152 Helen Mayo/Wife 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. 4 Donation 5 Donat Confessor Gorsuch Family Cemetery 8/23/00 Glencoe, Maryland 22. Name and Addrass of Facility Bryan W. Lemmon Funeral Home Clary 10 W. Padonia Road, Timonium, MD 21093 23a. Pert1. Enter the disease, or complishock, or leart failure. List only o that caused tha daath. Do not anter the mode of dying, such as cardiac or raspiratory arrast, on each line. Approximata Interval Between Onsat and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical . MGTASTATIC TRUSTATG 3 4600 Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) ... P.0. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COMONANY Ar Thry D136156 Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed page 2 1□ Yes 2□No 1 ☐ Yas 2 No 8 25. Was casa retarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Homa 5 ☐ Aesidence 6 ☐ Othar (Specify) 1□ Yes 2F7 No Certification: To After this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending invastigation after deeth.

Director: After deeth. 1 Yas 2 No 2 Accident 6 ☐ Could not be detarmined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 6 4 ☐ Homicide filled in Hospital 24 hours Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier adical tely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Senature and title of certifier.

State Registrar

DHMH 16 Rev 6/95

AUG 2 2 2000

31. Date filed (Month, Day, Year)

accept interest ND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Wiedefeld, MD 3346 Papermill Road

32. Registrar's Signatura

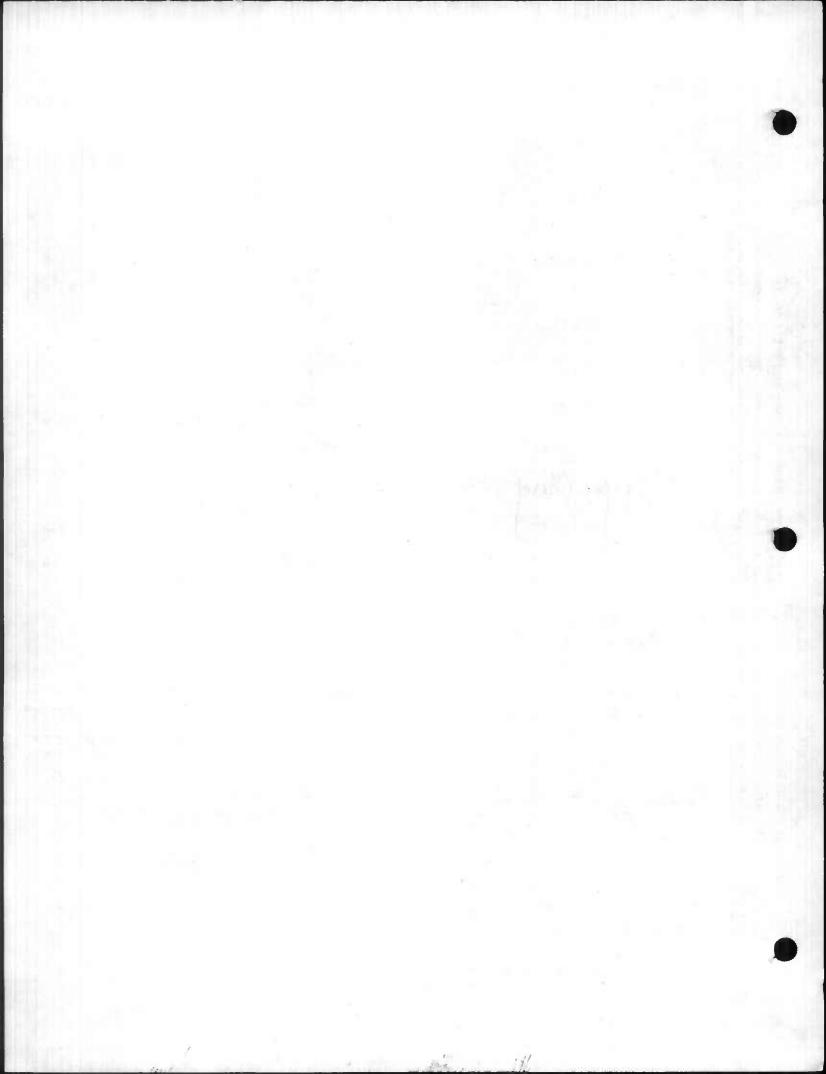
ar's Signatura

D33041

Phoenix, MD 21131

8-21-00

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 EKRITI **Physician** FVELYN 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE DILLON If Under 1 Yea 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 10 M 2 F Months Hours 68 218-28-3051 Yrs. Director 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2□No Funeral Director BAUTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21224 Herra 23a Pages 1 and 2 should be filed within 72 hours after death 12. Wes Decedent Ever in U.S. Armed Forces?

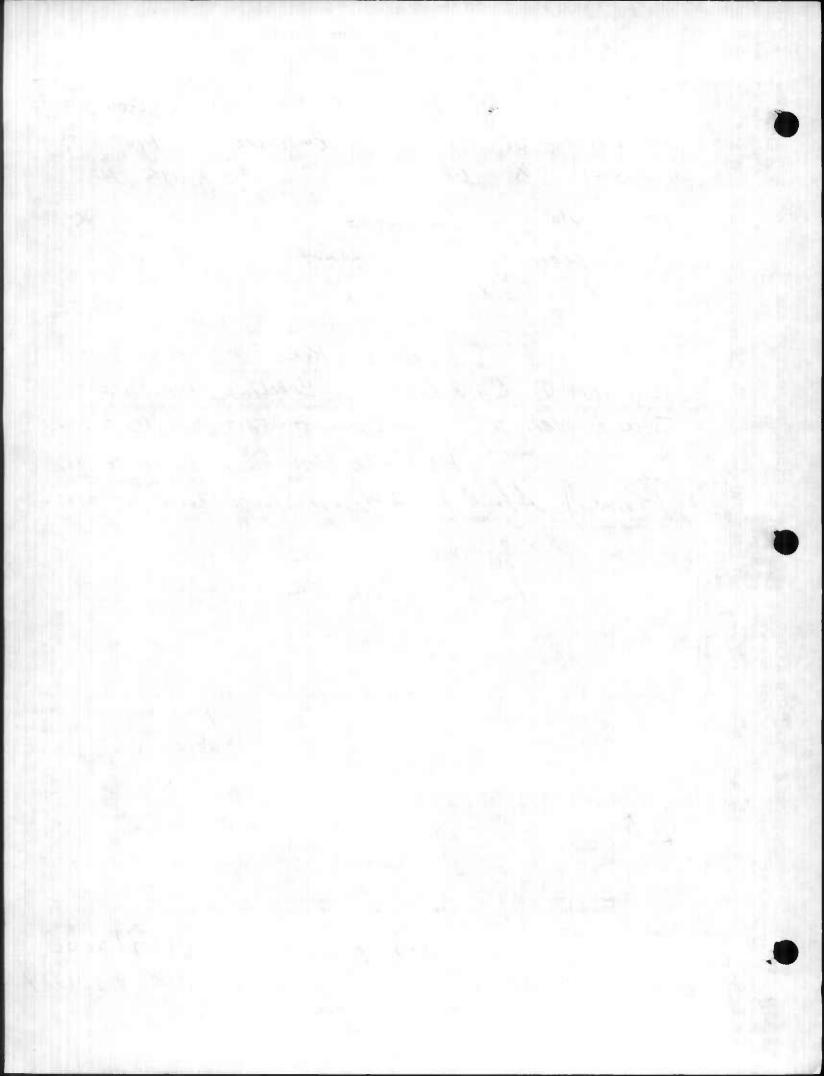
1 Yes 2 TNo If Yes, Give Yeer or Detes: 14. Rece - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than eny Injury or other traumatic event, the Monce. KER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) MEKRI BALTIMORE, MD. 21224 JOHN DILLON 20b. Plece of Disposition (Name of cemetery, cremetory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removel from State 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licenses BALTO, MD. 21224 23a. Part1. Enter the disease/of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vitai Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? page 2 should Completed After this certificate has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Physicien: 8 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4□ Nursing Home 5 Residence 6 □Other (Specify) within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral 27. Menner of Death 28a. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred Injury at Work? 5 Pending investigation or Attending 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, Ierm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital it Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signeture and title of certified 29c. License number 29d. Date signed (Morgh, Day, Year) 2000 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Dey, Year) AUG 2 2 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** 17, August 2000 2:50 pm 25 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner If Under 24 Hrs. 8, Date of Birt imoni 9. Birthp 5. Social Security Number 6. Sex last birthday) **Funeral** Months Days Hours 1□M 20 F Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland the Medical Examiner must be notified Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 82 212 nroe Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Raca - American I Bleck, White, etc. American Indian 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: þ 3 D Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. QO,NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 0 19a. Informent's Name/Reletionship (Type, Print) son) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3826 20b. Place of Disposition (Name of anor 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Mem. Par 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any le Joseph neral one 16 W. North Ave or the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, that failure is only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ARTERIOSCLEOTIC HEART DISEASE **Examiner** Due to (or es a consequenca of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events reaulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy Be Completed 1□Yes 2₩No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpetient 2 ER/Outpetient 3 DOA 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred

68760 Box P.O. Vital ö

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Pages 1 and 2 should be fit ment of Health and Mental H lant: If Item 27 is marked off

Department of Health Important: If Nem 27

Maryland 21215-0020

Baltimore,

Division

Medical Certification: To 8 within 24 hours a To the Funeral C To the

State

Registrar

29c. License number

D 15504

1 ☐ Yes 2 ☐ No

29d. Date aigned (Month, Dev. Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda, M.D.

5 Pending investigation

6 Could not be

2300 Dulaney Valley Rd

Injury

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Timonium, Md 21093

31. Date filed (Month, Pey Year) 2000

MXNetural

2 Accident

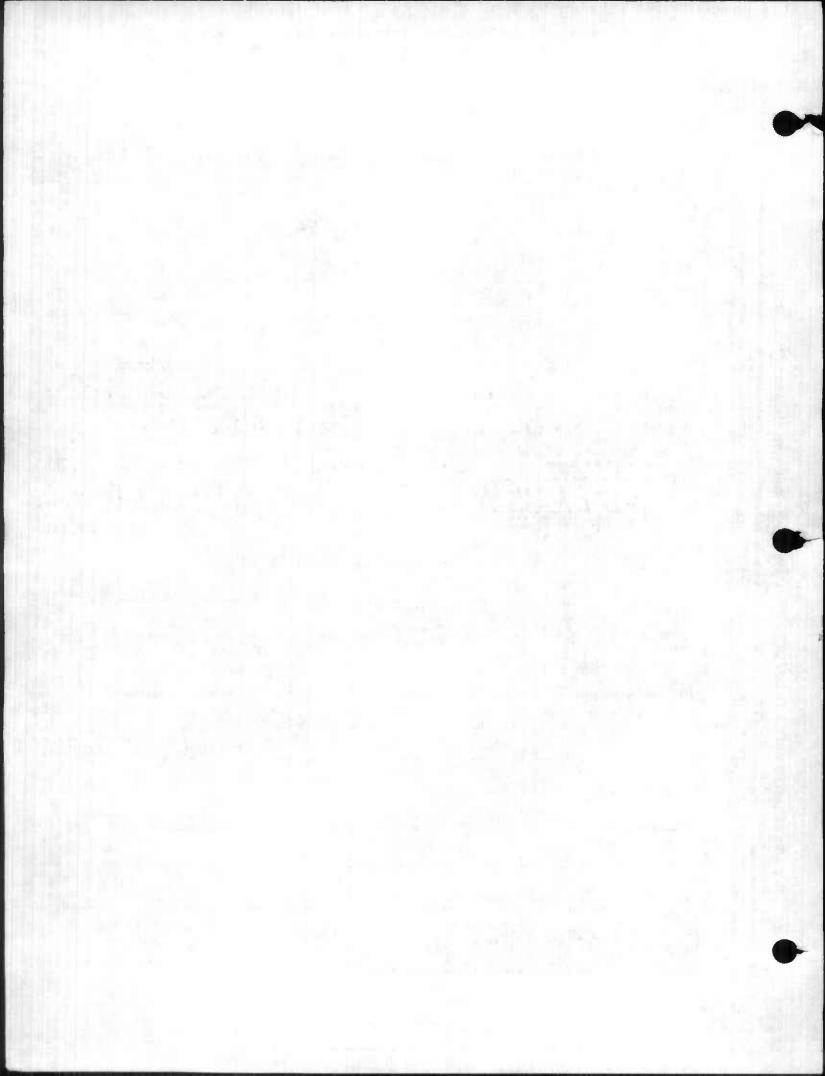
3 Suicide

29e Certifier

29b. Signature

4 - Homicide

32. Registrer's Signature



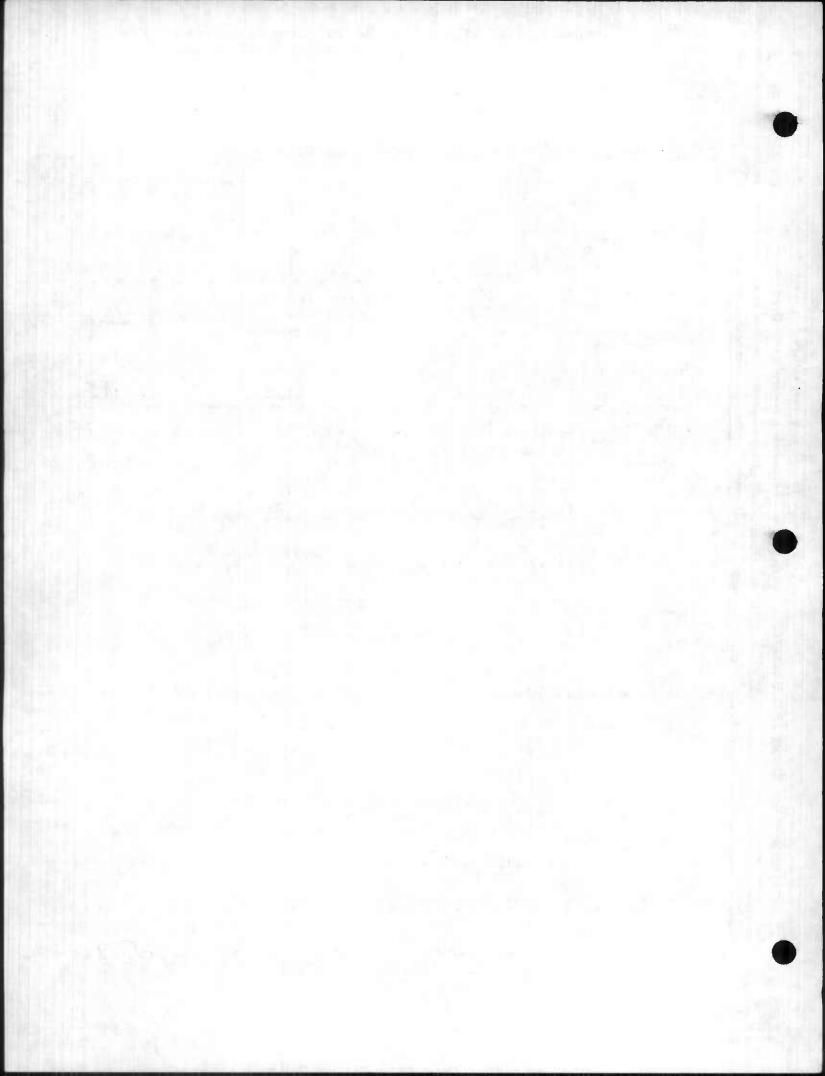
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State of Maryland / Department of Health and Mental Hygiene 00 264 94

	Certificate of Death	Reg. No.	20474
Physician	1. Decedent's Name (First, Middla, Last)	2. Date of Death /Month Day Year	3. Time of Death
/Medical	Mary Irene Moore	Hugust 14, 2000	0 /1.11
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		more City // r 24 Hrs. 8. Date of Birth 9. Bi	rthplace (Stata or Foraign
Funeral Director	196-38-2226 1 M 2 F 100 Yrs. Months Deys Hours Usuel Residence of Decedent	r 24 Hrs. 8. Date of Birth Min. June 29, 1900 V	ountry) 1 rginia
Bu .	10a. Sfate 10b. County 10c. City, Town or Location		10d. Inside City Limits
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be notified	10e. Street and Number / Apt. 10f. Zip Code	10g. Citizen of What C	ountry?
al E	2503 Violet Aug. 12095 2/2/5	US	A
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Be Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during mo:	st of working	s/industry
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8	17. Father's Name (First, Middle, Last) 18. Moth	ner's Name (First, Middle, Maiden Sumame)	LL MOINE
Be	Ascar Tohnson	Jaru Edman	1<
10		ber or Rural Reute Number, City or Town, State,	Zip Code)
	Mrs. Flizabeth C. Bacon 2501 Viole	+ Ave APTIN ROLL	n. Md. 21215
	20a. Method of Disposition 20b. Place of Disposition (Nama of cematery, cramatory or other place)	Date / 20c. Location - City o	Town, State
	1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	8/24/00 Lansdou	ine Md.
100	21. Signature of Funeral Service Licensee 22. Name and Address of Facil	Ruse Funeral H	ome.
-	Joseph J. MISS 2222 W. Nor	th Ave Balto, Mo	1.21216
	23e. Part1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock or heart failure. List only one cause on each line.	s cardiac or respiratory errest,	Approximate Interval Between Onset and Death
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	Sequentially list conditions, if any, leading to immediate cause. Enfer Undertying Cause (Disease or injury		
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Completed by			. Were autopsy findings available prior to
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Eo		1□ Yes 20 No	1 ☐ Yes 2 ☐ No
Ве Соп	25. Was case referred to medical 26. Plac	ce of Death (Check only one)	
5 0	axaminer? 1 Yes 2 No	lursing Home 5 Residence 6 Other (Sp	ecify)
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cati	2 Accident investigation M 1 Yes 2		
Certification:	3 Suicide 4 Homlcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)	28f. Location (Street and Number or I City or Town, State)	Rural Routa Number,
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edical	29a. Certifier (Check only one) Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, de and menner stated.	and place, and due to the cause(s) and manner ath occurred at the time, date and place, and d	es stated. ue to the cause(s)
Medical Ce	29b. Signature and fittle of certifier 29c. License number	29d. Dete signed (Mo	nth, Day, Year)
	Ametun H. Women DISC	503 August	19 2001
	30, Nama and address of person who completed cause of death (Item 23a) (Type, Print)	Hospital	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
)	Amatun Novem m. D. 40 maryland General	Hospital	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registrar	Alic 2 2 2000		

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26495 Certificate of Death Reg. No. 2. Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Day Year **Physician**)inified Miller NMN August 1210 PM 10 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Hospital Eme 5. Social Security Number 6. Sex Balt more If Under 24 Hrs. 8. Da Emergence 8. Date of Birth Month, Dey, Year) If Under 1 Yea Months Devs Gountry) ce (State or Foreign **Funeral** 1□ M 2 X F 375-28-813 Usual Residence of Decedent Devs Hours Director 12 should be filed within 72 hours after death with the Maryland n end Mental Hygiene. Is marked other than "natural", or frems 23s or 28s-f show 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director larviana more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 ol 0 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indien, 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Specify Completed by Year or Dates: 3 Widowed 4 □ Divorced ac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 0 Hone 0 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill ment of Health end Mental Hant: If them 27 is marked oth jury or other traumatic aven unk 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State 19e. Informent's Neme/Reletionship (Type, Print) (Son) Zip Code) 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition **Pate** 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from Stete 4 Donetion 5 Other (Specify) Department o Important: If any injury or 12000 reenmount remotori 22. Name and Address of Facility 21. Signature of Funerel Service Licensee Joseph ner 216 23e. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) orie Malnutrition /Medical Examiner Due to (or es e consequence of) Examiner 20phrenia The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest pue Due to (or as a consequence of) Box 68760, physician Medical Certification: To Be Completed by Physician/Medical the Due to (or es a consequence of) 50 detached for usa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 □ Probably d Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Ulcers page 2 this certificate has 1 Yes 1 ☐ Yes 2 No Physician: director. 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) uneral 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Netural 2 Accident To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After a property filled in by the funeral and the funeral property. or Attending 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specity) 4 Homlcide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29s. Certifier (Check only one)

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

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30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

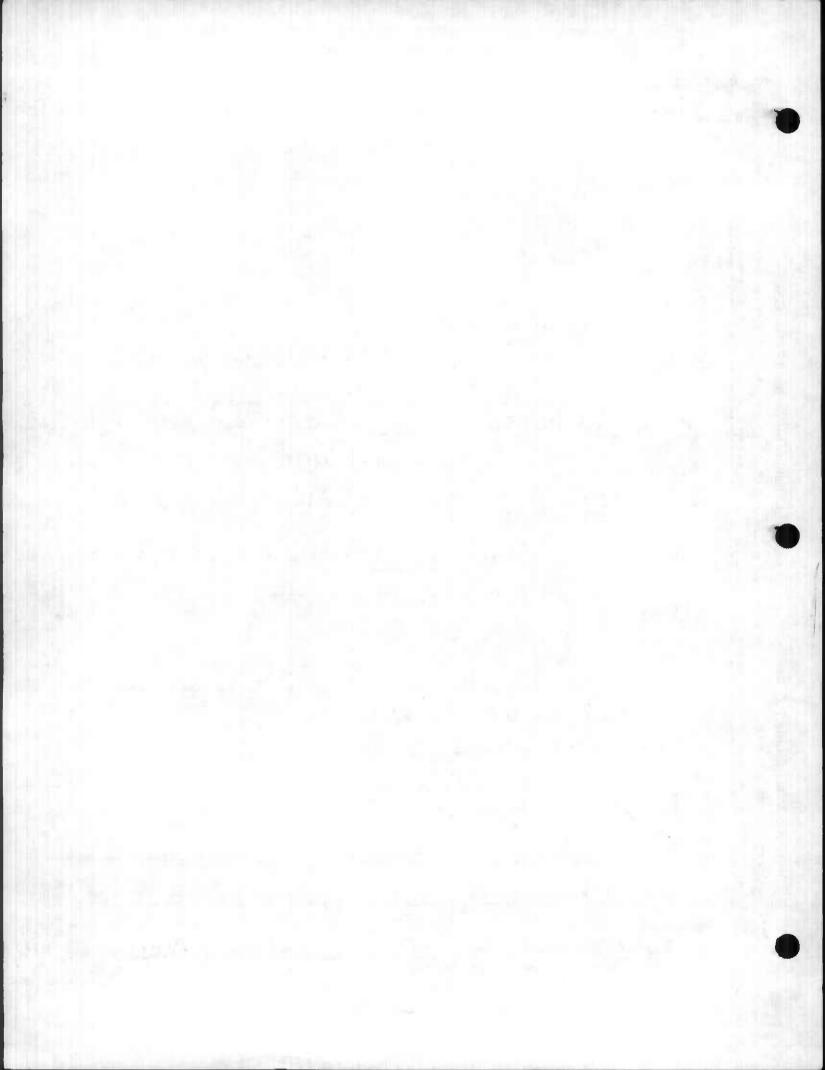
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32. Registrer's Signature

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day August 21, 2000
August 21, 2000
August 21, 2000 **Physician** Bessie Viola Meister 5:30 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Glen Burnie
If Under 24 Hrs. 8. Dat
Hours Min. Mo Mariner Health of North Arundel Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Yrs. Director 214-18-6023 Usual Residence of Decedent August 26,1909 Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director or flams 23a or 28a-f Md. Anne Arundel Pasadena the Medical Examiner must be notifie 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 Oak Drive 21122 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Nevar Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Py 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Hutzlers 8th Merchandising Dept 17. Father's Name (First, Middle, Last) Name (First, Middle, Maiden Sumame) 88 8 Mental Louis Phillips Preston Florence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ä Pages 1 and 2 s ment of Health an Department of Health a Important: If Item 27 is any Injury or other train 2005s. Alice LeCompte (Daughter 218 Oak Drive Pasadena, Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 _Qurial 2 _Cremation 3 _Removal from State 4 _Donation 5 _Othar (Specify) Cedar Hill Cemetery 8/24/00 Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Collens 3204 Mountain Road Padadena, Maryland 21122 23a. Part. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical 4 year Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue Box 68760. ata has been signed by the attending physician page 2 should be detached for usa es the buria Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the causs of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed by Division of Vital Records. 24b. Were autopsy tindings available prior to complation of cause of daath? 24a. Was an autopsy performed? certificata has 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director; After this certifical completaly filled in by the funeral director; 25. Was case referred to medical examiner? Medical Certification: To Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registra

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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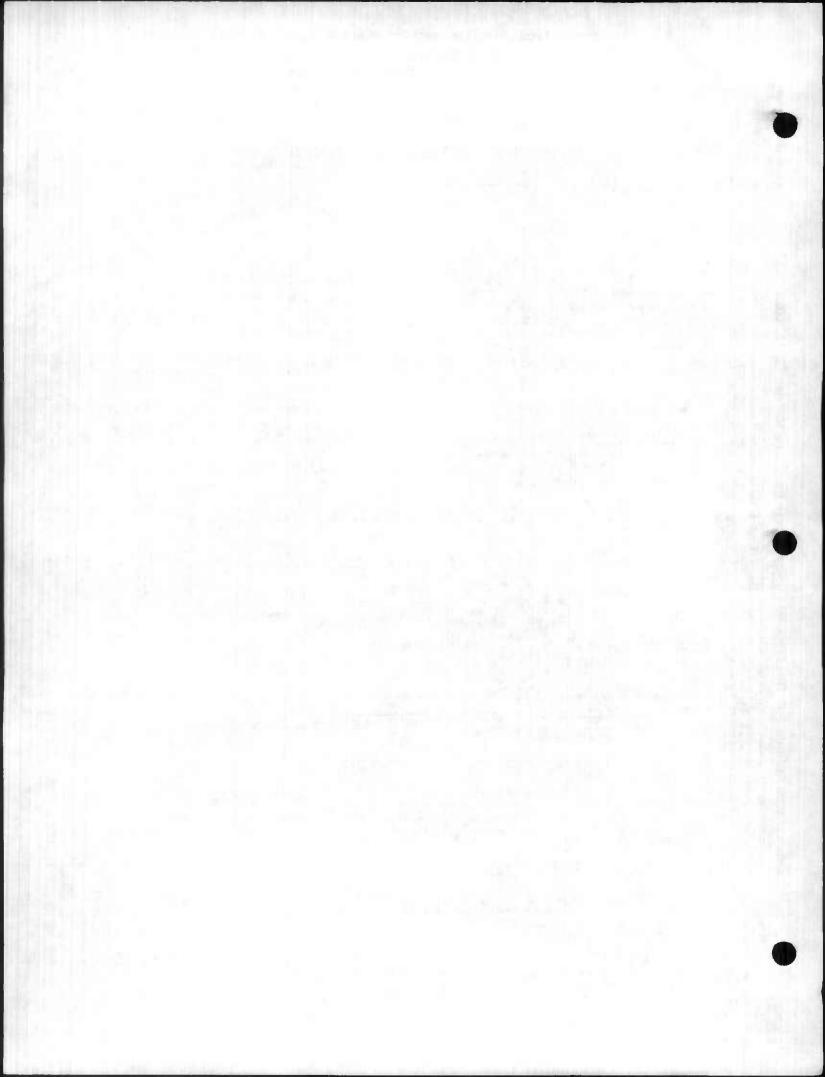
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32. Registrar's Signature

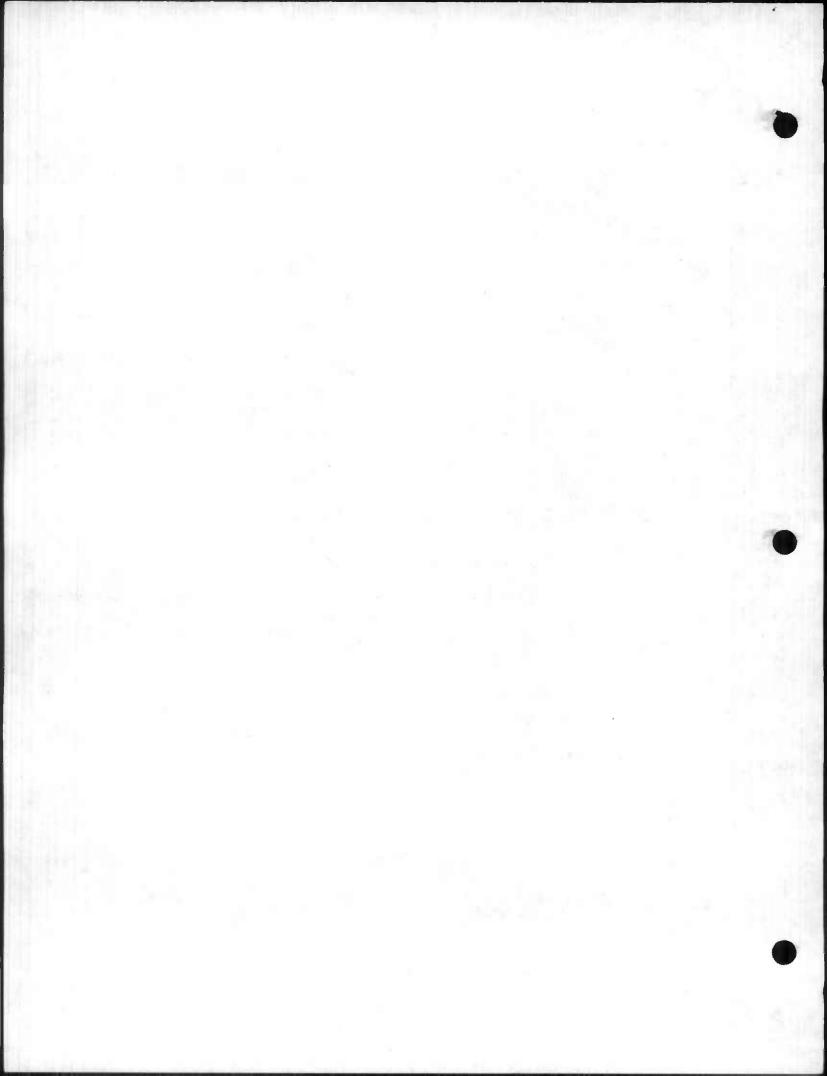
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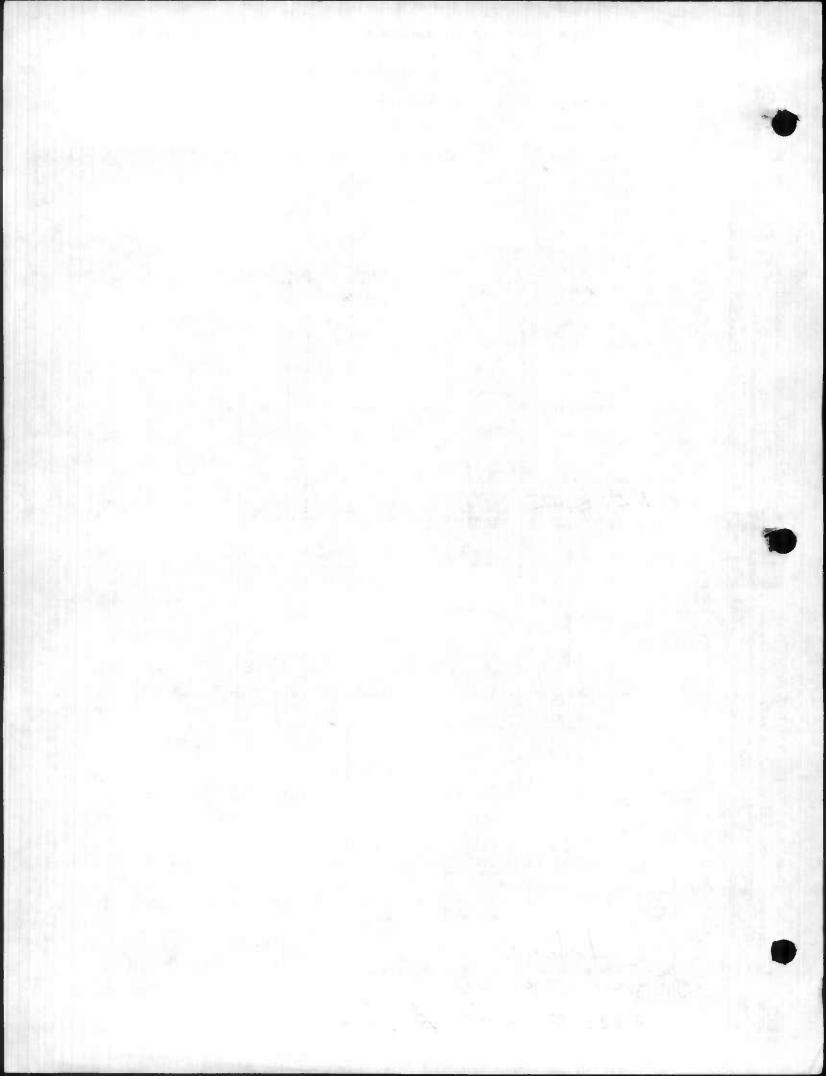
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	B	30. Name and address of person who co		Ba) (Type, Print)	1 0		
	MI	Harbor Hospit			Street, Bar	house, MO	21225
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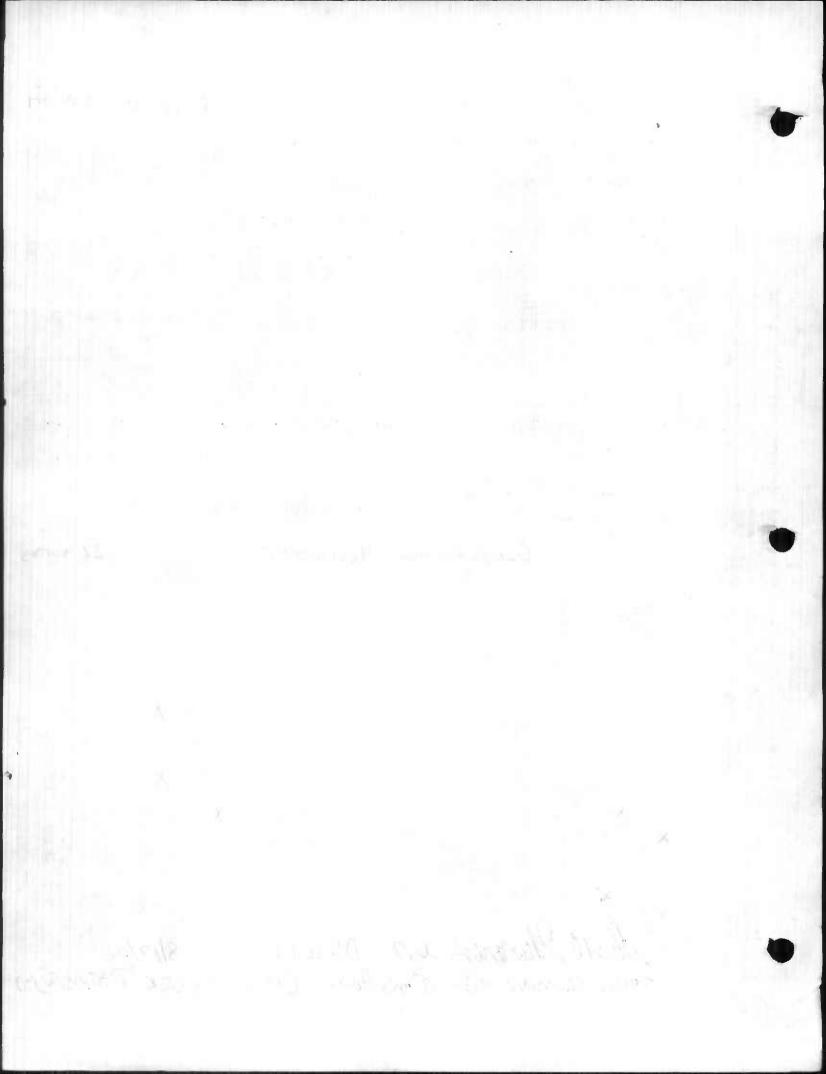


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0.0 Date - Month 3. Time of Beat 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 3:00 AM 00 Scott Eugene Muntean /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 100 Askewton Road Arundel Severna Park Anne If Under 24 Hrs. If Under 1 Yea 5. Social Security Number 7. Age (Iri yrs. last birthday) Birthpiace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. Months Davs 1 M 2 □ F Yrs 45 Director 278-52-7427 NOV 10, 1954 Ohio Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Ineide City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel 288-4 Directo Severna Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Name 23a 100 Askewton Road 21146 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 8 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: White À 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Pilot Aviation Sales 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Item 27 is manhad oth stry Injury or other traumatic even Be Eugene John Muntean Amelia Irene Longociu 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy A. Lynn/Wife 100 Askewton Road Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Metro Crematory, 4 ☐ Donation 5 ☐ Other (Specify) Inc. 8/18/00 Baltimore, MD 21. Signetur uneral Service Lice 22. Name and Address of Facility Zolward A. Cremation Society of MD, Inc. Edward A. 299 Frederick Road regorchik Baltimore, 21228 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical HULTIFORME . GLIUBLASTUMA 22 MONTHS Examiner Due to (or as e consequence of) Examiner burial-transit pue Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 20 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? After 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No ofter death Director: 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifier cai (Check only one) To the To the F 29c. License number 29b. Signeture el 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print); BATIMORE MO CRUSS4AN 31. Date filed (Month, Dey, Year) AUG 2 2 32. Registrar's Signature State 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26500 G787 9-16-WB Certificate of Death AMEND ITEM: #7 PER F.H. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** Month 12:34 P. BLAIZE AUGUSTIB 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner LANDR LARS BALLIMORE If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. lest birthdey) 5. Sociel Security Number 6. Sex 8. Deta of Birth (Month, Dey, Year) 416 9. Birthpleca (State or Foreign Country) **Funeral** Months Days Hours 190 M 2□ F 218 10 4390 84 Yrs. FEBRUARY3 MARY Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 25 No Director BALLIEBRE MARATORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVS 7808 10RZLAND 31334 Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, Whita, etc. 11. Marital Stetus MYas 2☐ No If Yes, Give Yaar or Datas: ₩ ₩ Ⅲ 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced THW "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ERCHANT 127 RS ARINE (ARITIMS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be should be 10 FRANCIS TULIO experiment of Heelth and A. Important II New 27 is managed injury or other 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Placa of Disposition (Name of MARKVILLE VICTOR 20a. Method of Disposition 20c. Location - City or Town, State AUL 18, cemetery, cremetory or other plecal 1 ☐ Burlel 2X Cremetion 3 ☐ Removal from Stata 1 ARYLAND Donetion 5 Other (Specify) FORZST 2000 EVANS FUNERAL CHAPLE
8800 HARFORD ROAD 21234 (ARY) LACY Approximate Interval Between Onset and Deeth 23a. Pert1. Enter the diseasa, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heert tailure. List only one ceut an each line. **Physician** /Medical Immediata Cause (Finel diseese or condition resulting in death) Examiner Examiner Sequentially tist conditions, it any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest pue d for use as the buria Box 68760 Physician/Medical Due to (or as a consequence of): P.0. signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. g 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy Completed 20 No 1 Yas 2 No 1 Yes after death.

Director: After this certifica 25. Was case refarred to medical Be 26. Place of Death (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: P 1 Yes 250 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Injury Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital
Within 24 hours a
To the Funeral Complataly filled edicai 29a. Certifier TS Certifying Physician: To the best of my multiple deth occurred at the time, dete and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and agdress of person no completed Item 23a) (Type, Print) 31. Date filed (Month, Dey, Year) 32 Flor State AUG 22 Registrar

ORIGINAL

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